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ABSTRACT

This issue of the CACD Journal includes theoretical proposals and practical reports of initiatives for innovation and change in the counseling profession. A theme feature section, "Reframing School Guidance and Counseling," examines changes in the state, district, and school. An additional feature section, "The Personal Side of Counseling," highlights feelings, opinions, and attitudes within and about the counseling profession. The following articles appear: "A Model for Self-Supervision in Counselor Education" (Gold); "Polarity Analysis and Management: An Alternative Approach to Unsolvable Problems and Unresolvable Conflicts" (Hurst and VanderVeen); "Cross-Cultural Comparison of College Students in Taiwan, Philippines, and the United States on the Inventory of Counseling and Development" (Salazar-Liu, Andberg, Michelucci, and Giddan); "Incorporating Behavioral Medicine into the Counselor Education Curriculum" (Gill-Wigal, Thorne, and McBee); "A Comparison of Screening Procedures in CACREP and Non-CACREP Programs" (Bradey); "The Long Lever: Reframing Guidance in Arizona Schools" (Johnson and Ammon); "Developing a District-Wide Outcome-Based Guidance Program" (Maliszewski, Pilkington, and Radd); "Who Is Your Counselor? Does it Really Matter?" (Lehmanowsky); "The Helping Person's Credo" (Levy); "Binding Pact" (Rizk); "A Proposed Category for the Diagnostic and Statistical Manual of Mental Disorders (DSM): Pervasive Labeling Disorder" (Levy). (JBJ)

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THE EDITOR'S MESSAGE

Pat Nellor Wickwire

This issue of the *CACD Journal* includes theoretical proposals and practical reports of initiatives for innovation and change in the counseling profession.

Joshua M. Gold proposes using an interactional balance of affiliation and directiveness in counseling, specifically in self-supervision of students in counselor education.

Joseph B. Hurst and Neil VanderVeen present a model for identifying, analyzing, and managing polarities for problems and conflicts that cannot be solved or resolved.

Eva Salazar-Lui, Marcia Andberg, Ernesto Michelucci, and Norman S. Giddan identify and compare characteristics of college students in the United States, Philippines, and Taiwan.

Jan Gill-Wigal, Charles Thorne, and Sandra McBee present a rationale for the incorporation of behavioral medicine in counselor education curricula.

John R. Bradey identifies initial and ongoing screening procedures for students in counselor training programs, and suggests the development of universal guidelines.

Guest Editor C. D. Johnson, in the theme feature "Reframing School Guidance and Counseling," recommends results-oriented counseling programs, and includes reports on state, district, and school change agentry. Sharon Johnson and Tina Ammon identify the steps and the results of conceptualizing, implementing, and evaluating Competency-Based Guidance statewide. Stan Maliszewski, Ross Pilkington, and Tommie Radd present the sequential development of a district-wide guidance program based on student outcomes. Mary Beth Lehmanowsky describes the planning, delivery, and evaluation of a school guidance and counseling program based on student outcomes and offered by a team of counselors.

In the continuing feature "The Personal Side of Counseling," three authors offer feelings, opinions, and attitudes within and about the counseling profession. Henry L. Levy presents a credo for the helping person. Sharon Rizk offers the poem "Binding Pact." David A. Levy suggests "pervasive labeling disorder" as a new diagnostic category.

Readers are cordially invited to enjoy the offerings of the authors in this issue. Readers are also invited to create and test new ideas and practices in the continued professionalization of counseling–and to forward manuscripts about thoughts, feelings, and actions for future issues of the *CACD Journal*.

THE CACD PRESIDENT'S MESSAGE

John Suter

As the California Association for Counseling and Development closes its 27th year as the major professional organization representing the counseling profession in California, we continue to expand our services to CACD members. While conventions provide guest speakers, workshops, and a time to meet with colleagues, the *CACD Journal* provides a quiet opportunity to examine, re-examine, and assimilate new ideas and opinions. It is an ongoing professional development and personal growth service that "keeps on giving." It also provides the opportunity for CACD members to share their expertise with others: what works for them, which problems need further exploration, in which directions they see the profession moving, and so forth.

The *CACD Journal* is a joint effort that takes a great deal of coordination and cooperation on the part of the Editorial Board and the individual contributors who have submitted articles. Pat Nellor Wickwire has very capably directed these efforts as editor since 1990 and again provides a publication which mirrors the vitality, scope, and concerns of the profession. We would like to especially thank those whose contributions you will be reading in this issue and encourage other members to consider sharing their articles. You will find it a very rewarding effort.

A Model for Self-Supervision in Counselor Education

Joshua M. Gold

This paper seeks to begin to bridge the gulf between the theory and the practice of self-supervision by master's-level counseling students. The proposed model emphasizes two important characteristics of effective counseling: affiliation and directiveness. Differing descriptions of counselor behavior are presented as a basis for the success, or lack of success, of counseling sessions.

With the expansion of the field of counseling, theories of supervision have evolved to focus student reflection on specific components of the therapeutic process. Supervision models can be categorized as psychodynamic, person-centered, and behavioral, with most supervisors favoring an integrated approach (Bernard & Goodyear, 1992). In family counseling, supervision has historically mirrored the supervisor's therapy of choice. Recent marriage and family therapy training models (Haas, Alexander, & Mas, 1988; Nichols, 1988) have identified the learning needs of student therapists as conceptual, emotional, technical, and relational, and suggested ways for supervisors to address these needs.

Challenge for Supervision

While these models serve as comprehensive educational guidelines for doctoral students and intervention guidelines for training supervisors, their complexity may transcend the comprehension and self-application of student therapists. In an attempt to bridge the "theory-practice gulf experienced by students" (Ronnestad & Skovholt, 1993, p. 396), a model based on directiveness and affiliation in counseling is presented. This model can be used by beginning counselor trainees in the analysis of therapeutic intervention. For the purposes of this discussion, the term "counseling student" refers to students who seek master's degrees in counseling, and the term "client" includes individual, group, couple, and family participants in counseling.

The therapeutic dynamics of affiliation and directiveness hold specific pedagogical meaning for the author, whose teaching responsibilities include clinical courses in the counselor education program and in the marriage and family counseling program. Students from these two distinct programs generally support different conditions for therapeutic change. The counseling students emphasize affiliation at the expense of counselor directiveness, and delegate direction and impetus for client discovery, learning, and change to the client. The marriage and family counseling students advocate counselor directiveness rather than ongoing affiliation of counselor and client, and seem to believe that therapy is something one does to, rather than with, clients, with the counselor responsible for therapeutic change. The two groups of students present parallel linear positions and insist that "more is better." A curvilinear position that integrates affiliation and directiveness and insists that a deficiency or predominance of either dynamic is countertherapeutic is recommended in this paper.

For the purposes of this discussion, counselor affiliation incorporates dynamics characteristic of a positive therapeutic relationship: rapport, trust, respect, commitment, and safety for risk-taking (Cormier & Hackney, 1993). Counselor directiveness encompasses counselor actions which focus and guide client attention and exploration toward specific

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topics and constructs. Client attention and exploration reflect the therapist's theoretical orientation, and may involve affective, cognitive, and/or behavioral priorities from intrapersonal and/or interpersonal perspectives.

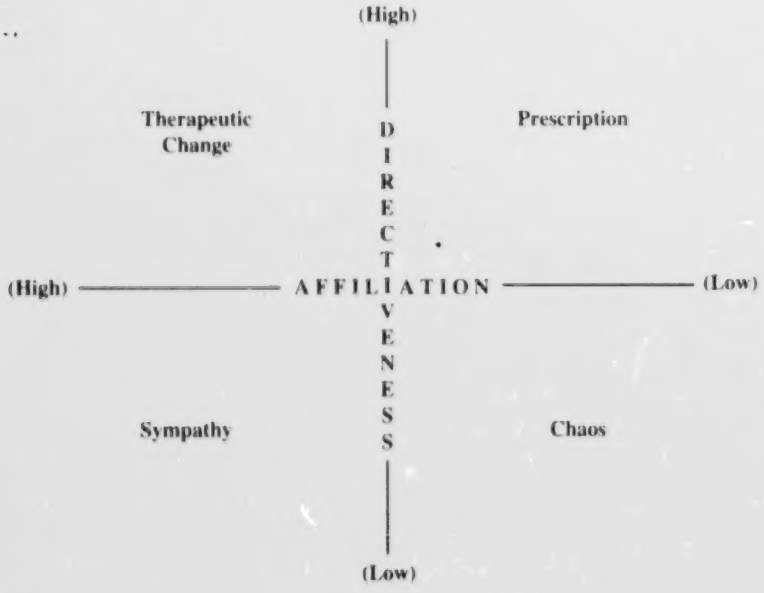
Counseling literature reveals support for the effects of the interaction of affiliation and directiveness on therapeutic progress (Bynum, 1991; Cormier & Hackney, 1993; Ediger, 1991; Fox, Kanitz, & Folger, 1991; Gelso, Hill & Kivilghan, 1991; Hackney, 1990; Henriksen, 1991; Schulz & Ertelt, 1991; Sexton & Whiston, 1991). Literature about the results of marriage and family therapy confirms therapeutic joining and other tactics as requisites for therapeutic change (Anderson, 1992; Avis & Sprenkle, 1990; Figley & Nelson, 1989, 1990; Minuchin & Fishman, 1981).

The Interactional Balance of Affiliation and Directiveness

In the proposed model, affiliation and directiveness interact in counseling, with the counselor primarily responsible for counseling processes and outcomes. Counselor and client affect, cognition, and behavior vary according to the applications of counselor affiliation and directiveness. The degrees and interaction of affiliation and directiveness and the probable outcomes are shown in Figure 1. Sessions characterized by high levels of counselor affiliation and low levels of counselor directiveness can be described as "sympathy," by low levels of affiliation and low levels of directiveness as "chaos," by low levels of affiliation and high levels of directiveness as "prescription," and by high levels of affiliation and high levels of directiveness as "therapeutic change."

Figure 1

Degrees, Interaction, and Probable Outcomes of Affiliation and Directiveness in Counseling



Counselor trainees and others will be able to recognize their communication and the interacting client communication that have or have not contributed to the success of a session. (See tables 1-4 for descriptions of counselor and client affect, behavior, and cognition that exemplify each quadrant.)

Table 1
High Counselor Affiliation and Low Counselor Directiveness (Sympathy)

	Affect	Behavior	Cognition
Counselor	pities client	offers condolences to client	sees client as victim
	protects client	rescues client	sees client as powerless
	blames perpetrator	comforts client	sees others in client's life as threatening to client
Client	feels championed	tries to get counselor to fight client's battles	believes self to be exploited
	feels cared for	blames external factors	believes others are ruthless
	feels protected	tells stories	believes counselor is client's only strength

Table 2
Low Counselor Affiliation and Low Counselor Directiveness (Chaos)

	Affect	Behavior	Cognition
Counselor	feels frustrated	parrots client words	believes that the client is inferior by virtue of being a client
	fears the power and limits of counseling	uses vague questioning for facts and details	believes that the counselor's task is to be passive
	feels overwhelmed by client helplessness	distances from client affect, especially pain	believes that it is horrible to challenge the client
Client	feels distrustful of the counselor's motives and actions	gives one-word responses to counselor questions	sees counseling as a waste of time
	feels confused by the counselor's passivity	deflects any counselor inquiry	sees no value in the counselor's input
	feels exasperated that counseling is producing no changes	displays closed posture to communicate disinterest or anger	begins to believe that the client is incapable of change

Table 3
Low Counselor Affiliation and High Counselor Directiveness (Prescription)

	Affect	Behavior	Cognition
Counselor	feels impatient with client's lack of change	lectures the client on meaning of events	believes the inability to see an obvious solution shows how weak the client is
	feels superior because issue and solution are so "easy"	advises the client on how to solve the problem	sees client as stubborn and opposed to helping self
	feels critical of client's mistakes and search for understanding	dictates how the client needs to take charge of life	sees client as lazy and won't tolerate that attitude
Client	feels attacked by lack of counselor respect for own ideas	resists counselor input (yes . . . but)	believes the counselor too pushy
	feels dependent on counselor for all direction	defers to counselor expertise	thinks that client will never be able to help self
	feels impotent to make the smallest decision independently	grasps at whatever immediate solutions are dictated	is resigned to needing long-term counseling

Table 4
High Counselor Affiliation/High Counselor Directiveness (Therapeutic Change)

	Affect	Behavior	Cognition
Counselor	feels connected to the client as a person	reflects all obvious client process and deeper meaning	has clear view of client's world
	feels eager to assist the client find a personal way	risks being corrected by client	offers input and helps client decide meaningfulness
	feels relaxed with the client's pace and with the need to direct	is spontaneous and flexible in one's style with the client	guides the client through process, doesn't lead or push
Client	feels respected in personal individuality	engages in self-focus, self-exploration, and self-evaluation	feels in charge of own life
	feels supported as he/she accepts personal strengths and weaknesses	sets realistic goals and expectations	owns strengths and weaknesses
	feels brave enough to face what has hidden previously	manifests encouragement and support of self	understands past and uses that information to chart a more successful future

The Student and Self-Supervision

For counseling students, this model integrates the three major constructs of supervision. From the psychodynamic perspective (Ekstein & Wallerstein, 1972), the counselor is challenged to be open to the experience of therapy and to assess the degree to which congruence or incongruence contributes to therapeutic progress. From the person-centered perspective (Rice, 1980), the counselor must acknowledge the value of the counselor-client relationship as the medium for the counselor to orchestrate client focus and to help the client learn more effective life skills. From the behavioral perspective, the counselor must learn, practice, and integrate therapeutic skills, enforced by positive client reinforcement of increased insight and change (Boyd, 1978).

For marriage and family counseling students, this model is an integration of the findings of Figley and Nelson (1989), asserting that "the person of the therapist is as important, if not more so, than the skill of the therapist" (p. 362). The support of therapist directiveness echoes the need for attention to therapist activity in promoting therapeutic change (Figley & Nelson, 1990). Through specific activities that reflect theoretical orientations, effective therapists accept responsibility for progress.

This model also generates general questions for the student counselor:

1. How successfully did I connect with my client in this session? What did I do that contributed to our success or lack of success? How did the client respond to my efforts? What do I need to do in the next session?
2. How successfully did the client and I attend to the issues and move toward the definition of "health" consistent with theory? What did I do that contributed to our success or lack of success? How did the client respond to my efforts? What do I need to do in the next session?

Summary and Recommendations

This proposal offers a supervisory model directed at students learning to be counselors with individuals, groups, couples, and families. The matrix of degrees of affiliation and directiveness predicts therapeutic progress, clarifies the interaction of counselor and client, and identifies counselor affect, cognition, and behavior as facilitators of therapeutic change. The practicality and comprehensiveness of this model for self-teaching needs review by educators and students. While in its formative stages, the model may expand the common language between those who supervise and those who are supervised.

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Polarity Analysis and Management: An Alternate Approach to Unsolvable Problems and Unresolvable Conflicts

Joseph B. Hurst and Neil VanderVeen

Strategies for solving problems and resolving conflict are essential in counseling and therapy. However, they are often inadequate because they require either-or choices between alternatives that may be interdependent. Polarity analysis provides a method for managing both-and situations where opposite, but interdependent, alternatives are involved.

Problem solving and conflict resolution are major strategies in counseling theory, practice, assessment, and supervision. In fact, client and counselor success are often defined in terms of how well and how finally problems get solved and conflicts get resolved.

Many clients continue to experience "profound personal conflict" from trying to establish and balance priorities and then feel frustrated, disoriented, confused, and guilty about choices they make regarding those priorities (Kinnier, Katz, & Berry, 1991). Often clients create new difficulties with their "inadequate and irrelevant" solutions to problems (Cormier & Hackney, 1987). Unresolved issues and unsolved problems negatively affect clients' confidence, esteem, efficacy, and determination, and trigger feelings of resignation, frustration, incompetency, and hopelessness.

The purposes of this article are (a) to describe situations called "polarities" in which independent polar opposites make it impossible to solve or resolve once and for all, and (b) to discuss how to analyze and manage them over time. When clients and counselors learn to recognize and manage polarities, they can reduce wasted effort and resources, avoid negative responses to recurring problems and conflicts, and increase clients' effectiveness and sense of accomplishment.

Distinguishing Polarities From Problems

Johnson (1992) points out the difference between both-and and either-or choices. Both-and polarities involve two dynamic, interrelated polar opposites (poles). The more people act to get to one pole, the less they automatically act toward its opposite. For example, the more people plan the less they act, or the more they act for themselves the less they do for others. Because the two poles of a polarity are interdependent, people can not choose just one as a solution while they neglect the other. Each pole of any polarity has both positive ("upside") and negative ("downside") consequences of thinking and acting. Polarities also have an infinite dynamic flow (as shown by the arrows in Figure 1) from the downside of one pole to the upside of its opposite, from that upside to the downside of that pole, to the upside of the original pole, and finally to the downside where the flow all began (Johnson, 1992). When people treat polarities like problems to be solved–with the downside of one pole being the problem and the upside of its opposite being the solution–they wind up experiencing the downside of one or both poles more than the upsides.

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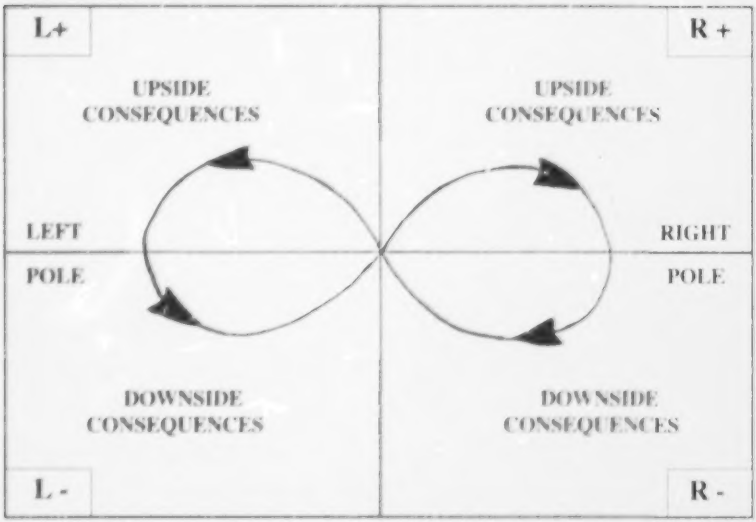
The generic structure and unblocked flow of polarities are illustrated in Figure 1. Any polarity diagram consists of two neutrally stated polar opposites on a horizontal axis across a field vertically divided into four consequence quadrants (Hurst, Keenan, & Minnick, 1992). One is facing a polarity if the difficulty is ongoing over time, there are

Figure 1
The Generic Structure and Predictable Flow of Polarities



two interdependent opposites, and action lacks finality. Polarities are like juggling or breathing; there is no final solution in any one toss, catch, inhale, or exhale.

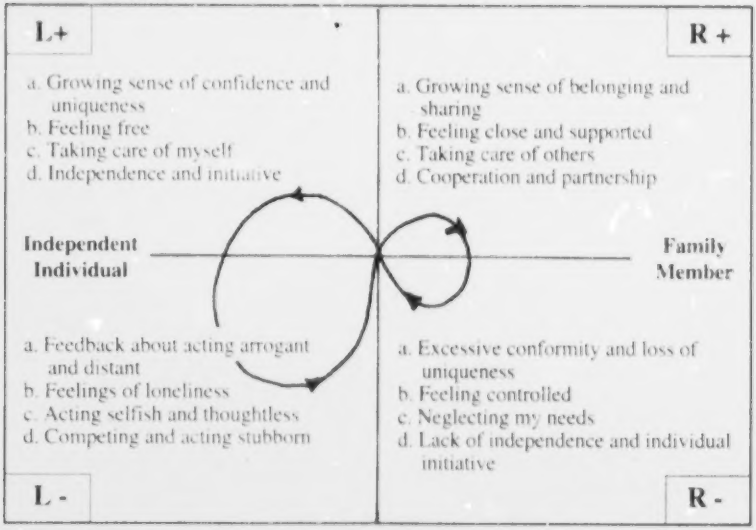
Either-or choices or conflicts consist of separate alternatives or opposites. For example, choosing one from three jobs is an either-or choice with a sense of "completion." Similarly, creating a way to save enough money for college tuition and planning for the future, given a lack of data, time, and clarity, sooner or later results in a final choice and action. A value conflict over ways in which a couple spend their leisure time has this either-or flavor. These situations do not involve an automatic return to the opposite direction, that is, to no saving, no planning, or no leisure.

Polarity Analysis

Once clients learn to diagram priorities by identifying the consequences of actions toward and away from poles, they can see and act on the need to manage polarities over time. In working with clients, the authors have charted the upsides and downsides of one or more particular polarities, and concurrently taught about polarities and their predictable dynamics.

Clients need to learn to chart their own polarities. The upside and downside consequences of one client's individual and family polarity are diagrammed in Figure 2. This client discussed the downside of being an independent individual (quadrant L-) with the main problem being loneliness and not getting along with family members (e.g., arrogance, distance, thoughtlessness, and stubbornness). The client wanted to rush to the family pole by moving home and "playing the game" to avoid arguments and be less lonely.

Figure 2
Individual and Family Polarity: A Client's Map


L+
R +
a. Growing sense of confidence and uniqueness
b. Feeling free
c. Taking care of myself
d. Independence and initiative
a. Growing sense of belonging and sharing
b. Feeling close and supported
c. Taking care of others
d. Cooperation and partnership
Independent Individual
Family Member
a. Feedback about acting arrogant and distant
b. Feelings of loneliness
c. Acting selfish and thoughtless
d. Competing and acting stubborn
a. Excessive conformity and loss of uniqueness
b. Feeling controlled
c. Neglecting my needs
d. Lack of independence and individual initiative
L -
R -

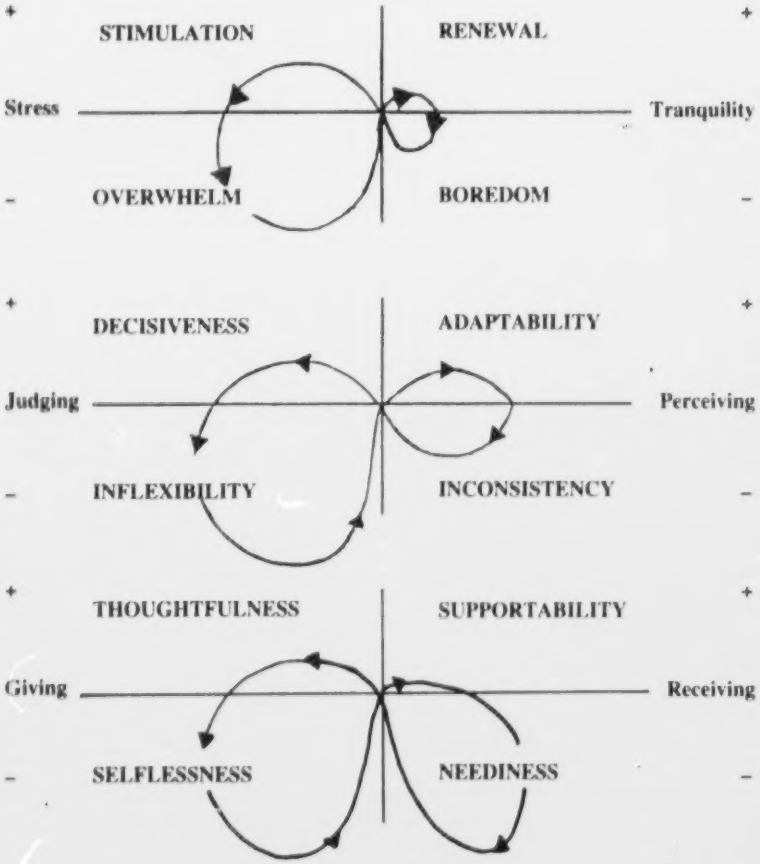
As the client discussed important goals related to belonging, intimacy, and working together, the counselor asked: "What are some of the important benefits about being by yourself now?" "Well, I've gained confidence, feel free, take time for myself, and act independently." (See quadrant L+.) "Please write on the chart in that box what you just said," requested the counselor. "I would like us to set goals that include benefits of the upside of family you intend to achieve and benefits of being on your own you intend to keep."

Once the client and counselor discussed and completed all four lists of consequences, they could see how an impulsive move back home could lead to rapidly experiencing some of the downside consequences of overemphasizing family to the total exclusion of individuality. A polarity that "flips" from the downside of one pole to the downside of the other (Johnson, 1992) happens when people have waited, refused to risk and overcome their fears, or been forced to move toward one pole so long that shifting causes overreaction. (See arrows in Figure 3 that represent deeper swings into the downsides and short ones into the upsides.)

Polarity analysis refers to the careful, specific identification of the two poles and their concomitant upside and downside consequences. To facilitate complete polarity analysis, four questions are needed:

1. What difficulties occur when you overemphasize the – pole and neglect the other pole? (downside of present pole: L–)
2. What benefits could result from your planned actions toward this other pole? (upside of other pole: R+)
3. What difficulties would result from focusing only on this new pole while ignoring the other? (downside of new pole: R–)
4. What are the benefits of emphasizing the present pole? (upside of present pole: L+)

Figure 3
Polarity Gallery: A Picture of One Client's Polarities



Polarity analysis also involves drawing a history line (arrows tracking where the client has been in the past, including dates). Often, identifying the elements of one polarity uncovers associated problems and other related or unrelated polarities that clients have been managing without knowing it. In addition, discussion of upside or downside outcomes tends to increase clients' sense of responsibility for the consequences of their actions and perspective on how other people in their lives are involved and affected. Acknowledging present upside consequences often leads to higher esteem, pride, and sense of accomplishment.

Figure 3 is a polarity gallery that reflects the polarities one client and the counselor identified. Note that the single terms label and represent specific outcomes the client and counselor identified together. Notice how some of these polarities have drastically skewed flows (arrows deep into one downside) that reflected this client's strong, safe preferences for one pole, deep fear and uncertainty regarding the other, and being forced by a parent

to emphasize one pole. Discussion over several sessions focused on acknowledging the upsides of the preferred poles, identifying the downsides of the new poles, the benefits of moving toward the new poles, and the continued downsides of rigidly adhering to habitual preferences.

Managing Polarities

"The objective of Polarity Management is to get the best of both opposites while avoiding the limits of each" (Johnson, 1992, p. xii). Clients that are managing polarities will spend most of their time experiencing the benefits of one pole and then the other. Having learned to be sensitive to any signs of a shift toward a downside, clients use their experiencing of negative consequences as signals to shift their focus toward the other pole. Visually this would look like two large loops in the upsides with very small loops in the downsides of both poles.

Even effective polarity management results in clients experiencing some downside consequences. To a large extent, however, such experiences are not seen as signals of ineffectiveness or failure as in the past.

In supporting clients' effective polarity management, counselors have several roles. Obviously, they have to promote polarity identification, analysis of upsides and downsides, and concrete, outcome-focused discussion. By emphasizing visual diagramming and writing, counselors model a thoughtful, focused approach to polarity identification. Counselors need to share their personal polarity management successes and setbacks and those of other clients so that clients are exposed to concrete examples, derive encouragement and support, and validate their own "ups and downs" with polarity management.

Another vital role of counselors is preventing clients from "falling for" the seductive "one-pole" and "merged-pole" myths. Many clients unconsciously believe that if they stay at one pole, they will get the upside and some of the downside of that pole and avoid the downside of their least preferred or most feared pole. Yet, the reality of polarity dynamics is just the opposite: "over-emphasize one pole and you get its downside . . . over-emphasize for a long time and you get both downsides" (Johnson, 1992, p. 156). The way to address this is to discuss fully the benefits to maintain and expand, and then discuss what to prevent, and most importantly, the results most feared. Plans for action toward the new pole can be made, identifying the benefits of the "new upside" and the "reduced downside" consequences as intended goals.

While the one pole myth comes from either-or thinking, the merged pole myth – that clients can combine the upper two quadrants of any polarity and act toward both poles simultaneously while avoiding both downsides–is a product of both-and thinking. This "best of both worlds" or "have it all" attitude seductively has clients trying to embrace both poles, resisting any shift of focus. "My career and my daughters both come first!" asserted one client. Counselors need to keep promoting healthy shifting of emphasis and focus, even if brief or momentary.

Techniques

The authors' own use of polarity theory and practice has blended a shifting focus between using familiar techniques and approaches (adapting common techniques to the polarity context), on the one hand (stability pole), and trying and inventing new techniques to bring polarity analysis and management into work, on the other hand (change pole).

A number of techniques can be used. These include:

1. Developing polarity diagrams that illustrate important consequences, historical trends, and future possibilities if any polarities are managed effectively or ineffectively.
   Filling out blank polarity diagrams.
2. Brainstorming blocks, supports, and new ways to shift poles effectively.
   Visioning and imaging exercises to stimulate consequential and futuristic thinking.
3. Physical "walk throughs" where blank polarity axes are taped on the floor and clients move around and discuss what it is or could be like to shift to new pole and then shift back again when necessary.
4. Directive teaching and coaching.
5. Priority- and goal-setting discussions and exercises based upon identified upside and downside outcomes.
6. Couple counseling focusing on the pair's different preferences for opposite poles and polarities' predictable results and dynamics.
7. Journaling about polarity experiences and developing written action plans.

Self-assessments identifying powerful personal polarities can play a diagnostic role in identifying such polarities as introversion and extraversion, intuition and sensation, thinking and feeling, and judging and perceiving (Hurst, 1990; Myers, 1987).

Conclusion

Polarities are not new to counseling. Perls (1969) used intrapersonal opposites as foci for his Gestalt therapy, while Kelly (1955) asserted that people adhered to certain poles that increase their ability to anticipate events and consequences. However, polarity analysis and management principles add a number of new approaches to nagging and recurring presenting problems. While the potential value of polarity theory and practice is very high, it is still very undeveloped, untested, and unresearched. One key to effective polarity analysis and management is modeling. Counselors need to share personal and other clients' examples of polarities in a way that illustrates how to identify and deal with them. Not all problems are unsolvable, but knowing which ones are is a valuable skill.

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Cross-Cultural Comparison of College Students in Taiwan, Philippines, and the United States on the Inventory for Counseling and Development

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This study compared the performance of Taiwanese, Filipino, and American students on the Inventory for Counseling and Development (ICD). Results showed significant differences among these groups of students on such factors as alienation from environment, anxiety, ambition, sociability, persistence, and sexual attitudes. The ICD may provide a systematic approach to the identification of important individual and group differences and similarities among international students.

There is mounting concern over the matriculation of international students in American universities. International students are at risk for problems with psychological adjustment and academic success because of many factors, including personality styles and ethnic minority status (Abe & Zane, 1990; Gim, Atkinson, & Whiteley, 1990). Better understanding of such students while they are in their countries of origin is needed to prepare for adjustment and satisfaction in host countries.

Cross-cultural personality assessment of Asian college students is critical for students, staff, and faculty. Abe and Zane (1990), for example, found that foreign-born Asian students exhibited greater levels of intrapersonal and interpersonal distress than U.S.-born Asian and Caucasian students. Gim et al. (1990) found that the severity of Asian-American student concerns was related to acculturation and ethnicity. Fernandez (1988), in a study of Southeast Asian college students, concluded that knowledge and appreciation of cultural background and early socialization significantly increased the effectiveness of cross-cultural counseling and advising activities. Fukuyama and Greenfield (1983) found significantly lower levels of assertiveness among Asian-American college students than among their Caucasian counterparts.

International student enrollment in the U.S. now numbers over 400,000 (Zikopoulos, 1990). Very large increases (e.g., Asian, 108%; African-American, 13%; Latino, 53%) in ethnic minority group populations occurred from 1980 to 1990 (Sue, 1991). Asians comprised the largest subgroup of international students in the U.S. in 1990, nearly 54% in 1989-90. They are among the fastest growing groups of internationals (Zikopoulos, 1990). Taiwan now has over 30,960 students, an increase of 37% since 1985.

Social and educational norms in countries such as Taiwan and the Philippines have been changing rapidly, partially if not largely due to Western influence; important differences with American norms still seem to exist (Ying, 1991). The diverse

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cultural environments which shape college students intensify the need for objective information in a systematic format for academic advising, career planning and educational planning (Charles & Stewart, 1991).

This article describes a cross-cultural comparison of college students in Taiwan, the Philippines, and the United States on a variety of personality characteristics and motivational traits using the new multi-scale objective Inventory for Counseling and Development (ICD) (Giddan, 1991; Giddan, Creech, & Lovell, 1988). The choice of Asian countries for the study of cross-cultural validity is especially timely and relevant to American higher education and society. This study identified Taiwanese, Filipinos, and Americans as "cultural" groups since the Asian students examined were not yet attending American universities. The task in studying these cultural groups was to consider similarities and differences on ICD scales, their relationships with culture and ethnicity, and any potential bias. Meaningful comparisons and assessments of international college student personality and performance by the ICD offer college faculty and advisors a standardized objective procedure, and alter the need to rely exclusively on cognitive tests or their own subjective evaluations of noncognitive factors.

The Inventory for Counseling and Development

The Inventory for Counseling and Development is a standardized objective personality inventory adopted for clinical use and research at several hundred universities and colleges since its publication (Giddan et al., 1988). The ICD measures separate personality traits, motives, cognitive styles, values, and attitudes which are salient and significant in contemporary American college life. The separate objective scales cover conventional characteristics such as test anxiety and intrinsic and extrinsic motivation; relationships with faculty; academic achievement; and political, social, and sexual attitudes. The ICD consists of 3 validity scales, 15 substantive scales, and 5 criterion scales, all based on 449 true-false items. The substantive scales are insecurity, alienation, exam tension, ambition, persistence, practicality, sociability, teacher-student interaction, intellectuality, originality, adaptability, orderliness, liberal-conservative, socio-political interest, and sexual beliefs. The ICD has shown evidence of validity, reliability, and usefulness, as well as fairness and sensitivity to women and ethnic minorities.

The ICD was first developed to predict academic performance of freshmen at Stanford University; the scope and the capacity of the instrument have since been broadened. In addition to forecasting various aspects of academic performance, the ICD now represents a comprehensive device for use in counseling, evaluating, and educating college students and other adults. ICD capacity to improve the prediction of academic achievement in higher education is a singular feature; traditional noncognitive approaches to predicting achievement have not provided precise forecasts that are generalizable across settings and groups (Gough & Lanning, 1986; Tracey & Sedlacek, 1984).

Method

The Inventory for Counseling and Development was administered to American college students in the U.S., and to Filipino and Taiwanese (Republic of China [ROC]) college students in their countries of origin. The American sample consisted of 660 females and 520 males who attended a variety of institutions throughout the

country. These included The University of Toledo, Bowling Green State University, Defiance College, Monroe Community College, Oregon State University, Goddard College, California State University at San Bernardino, and the University of Michigan. Different regions of the U.S. were represented in the standardization sample, in addition to a mix of public and private institutions. The minority presence in the sample generally reflected that of each institution, averaging about 5% to 10% depending upon the specific definition of minority. Differences between the scale score distributions for American men and women were found; these differences were usually less than one-half standard deviation.

The Filipino sample consisted of 53 females and 51 males who completed the ICD while attending West Visayas State University in Iloilo, Philippines. The Taiwanese sample consisted of 32 female and 25 male college students who took the ICD while attending Temkang University in Taiwan, ROC. All of the international students were volunteer college sophomores, ages 18 to 23, studying liberal arts on a full-time basis. Prior to taking the ICD, an English reading test was administered to the Filipino and Taiwanese students to evaluate and minimize the effects of language on ICD scores. The reading test was identical to that used during the MMPI restandardization project (Graham, 1990). Only students who passed the reading test were included as subjects for this study.

Two-way analyses of variance (ANOVAs) were used to assess differences in group mean scores on each of the 15 ICD substantive (content) scales. The independent variables were gender and cross-cultural background; only data for the latter are reported here. The dependent variable was the individual scale score. The hypothesis was that there are no differences in the raw mean scale scores for the cultural groups studied. Following a significant *F* test, the Scheffe method (controls for Type I experiment wise error) was used as a post hoc procedure to compare group means, as reported in Table 1.

Results

Cross-cultural background was statistically significant for the substantive scales of the ICD, with the exception of intellectuality and socio-political interest. The *F* values for cross-cultural background are shown in Table 1. The following analyses focus on the 13 substantive scales (11 of which were significant: $p<.01$) for which there was a significant main cultural effect. Only one scale, exam tension, showed an interaction effect in that men and women scored differently depending upon their cultural identification. The pairwise mean differences exhibited by the three culturally distinct groups are highlighted below.

The 25 mean comparisons of the three groups which were statistically significant beyond the .05 level are reported in the last column of Table 1. With approximately a 1:2 ratio between raw scores and *t*-scores, 5 raw score points approximate 10 *t*-score points. When a raw mean difference between groups reaches the size of 2.50, a *t*-score mean difference between groups of at least one-half standard deviation is suggested. Scores for the three groups differed in particular on the alienation, ambition, sociability, and sexual beliefs scales (i.e., for these scales, the three groups were characterized by mean raw score differences greater than 2.80 in two of the comparisons), and, with less clinical significance, on the insecurity, exam tension, persistence, and adaptability scales (i.e., group comparisons were characterized by mean raw score differences which averaged 2.00 or more on two occasions).

Table 1
Mean Scores and Significant Differences on the ICD Substantive Scales

	Filipino $n = 104$		Taiwanese $n = 57$		American $n = 1,180$		Cross-Cultural	Significant Mean Comparisons
	M	*SD*	*M*	*SD*	*M*	*SD*	*F* Value	
Insecurity	16.42	4.38	16.47	4.65	14.19	5.25	13.18**	P-A*, T-A*
Alienation	11.34	4.28	14.70	4.19	9.71	5.41	27.99**	P-T*, P-A*, T-A*
Exam Tension	11.20	4.28	13.84	4.28	13.48	5.39	9.17**	P-T*, P-A*
Ambition	19.06	4.53	15.21	4.82	19.63	4.88	23.00**	P-T*, T-A*
Persistence	16.00	3.70	13.75	2.88	14.09	5.29	6.89**	P-T*, P-A*
Practicality	18.27	3.92	16.25	3.92	18.02	4.01	5.76**	P-T*, T-A*
Sociability	13.23	3.93	13.33	2.95	16.20	4.38	32.96**	P-A*, T-A*
Teacher-Student	14.35	4.11	12.23	4.24	14.98	5.64	7.20**	T-A*
Intellectuality	15.56	4.66	16.25	4.03	15.64	5.20	0.41	—
Originality	10.51	2.99	12.04	3.92	13.23	4.61	18.62**	P-A*
Adaptability	15.38	4.34	17.72	3.98	15.80	5.31	4.21*	P-T*, T-A*
Orderliness	19.26	4.19	17.47	4.32	19.15	5.12	3.15*	T-A*
Liberal-Conservative	14.69	2.68	15.14	2.42	13.29	3.81	13.08**	P-A*, T-A*
Socio-Political	14.07	3.29	15.26	2.22	15.72	4.57	2.44	—
Sexual Belief	8.83	4.09	12.60	3.32	14.99	5.47	67.93**	P-T*, P-A*, T-A*

Note. P=Filipino, A=American, T=Taiwanese.
*Significant at .05 level
**Significant at .01 level

Score comparisons for the three groups suggested the following:

1. The Taiwanese were more alienated and estranged from their environment than either the Filipinos or the Americans.
2. The Filipinos and the Americans were more ambitious and achievement-oriented than the Taiwanese.
3. The Americans were more sociable and needed less privacy than either the Taiwanese or the Filipinos.
4. The Taiwanese and the Americans were more liberal and less conservative in their sexual attitudes than the Filipinos.

With lower clinical significance:

1. Both the Taiwanese and the Filipinos were generally more anxious and insecure than the Americans.
2. Both the Taiwanese and the Americans had more exam or evaluation tension and anxiety than the Filipinos.
3. The Filipinos were more likely to start a task and persist than either the Taiwanese or the Americans.
4. The Taiwanese were more adaptable and open-minded than either the Filipinos or the Americans.

Discussion

The results of this study documented and supported the potential usefulness of the ICD substantive scales with college students from Taiwan, the Philippines, and the United States. Variability of ICD scale scores occurred within each cultural group, and 25 statistically significant mean differences appeared between the American sample and the two Asian samples. Group differences were consistent with findings from other empirical and clinical studies.

There is empirical support in earlier studies for the signs of anxiety and discomfort found among the Taiwanese students. Sue, Ino, and Sue (1983) found that, while Chinese-American students were as assertive as their Caucasian counterparts on all behavioral measures, on self-report measures Chinese-American students were more likely to report (a) anxiety in social situations, (b) greater apprehension in evaluative situations, and (c) lower assertiveness than Caucasian students. Similar results were obtained by Sue, Sue, and Ino (1990) for Chinese-American and Caucasian-American female college students. Abe and Zane (1990) found greater levels of intrapersonal and interpersonal distress among foreign-born Asian-Americans than among U.S.-born Asian-American and Caucasian-American college students.

Would the Taiwanese students who earned particularly high scores on the alienation scale feel even more alienated and estranged if they were in higher education in the United States? The answer suggested by Ying and Liese (1990) data is affirmative, since Taiwanese students experienced a significant increase in depressive symptomatology after arrival in America. An academic advisor or guidance counselor could conceivably employ stress management and relaxation programs with such students, either before or after emigration.

The Filipino students had significantly lower scores in evaluation anxiety. That portends academic success, as does the fact that they had significantly higher scores on the persistence scale. The Filipino students appeared more conservative in their sexual attitudes and beliefs than the other groups. This may suggest specific matched

college selection, or, alternatively, the delivery of information about cultural norms, beliefs, and values about sexuality in the United States.

Both Asian groups differed from the Americans in other ways. Filipino and Taiwanese students scored higher on the liberal-conservative scale, but lower than the American students on the sexual beliefs scale. Asian students appeared more liberal and progressive on matters of politics and socio-economic issues, but more conservative and traditional on attitudes and beliefs connected with sexual behavior. American students appeared more sociable, more personally secure, and less anxious than the Asian students.

Conclusions and Implications

The results of this comparative cross-cultural study of the ICD were generally consistent with earlier findings, although cautions should be noted. Since the two Asian college samples were not necessarily students to be recruited for college or graduate study in the United States, care must be taken not to overgeneralize the results. No follow-up was conducted; therefore, accuracy of the ICD predictions was not determined.

Directions for future research and development of the ICD were suggested. The ICD was initially developed on volunteer American (largely Caucasian) college students. Separate norms are now needed for Asian-American and for African-American college students. Larger samples of college students in these Asian countries are needed, in particular, Taiwanese and Filipino students recruited and attending college in the United States. The establishment of local ICD norms would also be advisable and beneficial to students and counselors.

Future research is needed to identify differences between men and women, and within and between cultural, national, and ethnic minority groups on the ICD scales. ICD scale content may have drawn different reactions tied to unidentified cultural factors, for example, language, values, religion, and degree of family support (Boyer & Sedlacek, 1988).

As the ICD employs multiple content scales and variables, it could be further adapted to fit Sue's (1991) ideal parallel design research model with equivalent content measures developed simultaneously in different cultures:

> To represent accurately ethnic minority perspectives, research must develop separate but interrelated ways of conceptualizing the behavioral phenomena of interest, one based on a Western conceptualization, the other reflecting an ethnic minority interpretation. Essentially, parallel design consists of two linear approaches, each based on an alternative cultural viewpoint. In parallel research, it is incumbent upon the researcher to develop a priori two sets of descriptive and explanatory variables. Too often misinterpretations of ethnic minority behavior occur due to a lack of a proper conceptual framework. (p. 68)

This study encourages speculation on preventive programs in which the process of personal, social, and academic evaluation for international students is started early (Jensen & Jensen, 1983). Recruitment and admission would be broadened in such a view to include cultural orientation and academic counseling. As an example, Taiwanese and Filipino students here might better recognize differences between their culture and the U.S. culture and find ways to cope and adjust more readily to the American educational environment (Ying & Liese, 1990).

Programming could be done on a pre-college or pre-professional basis, with a counseling and guidance thrust which employs noncognitive evaluation instruments such as the ICD prior to U.S. enrollment, the description of student services, and the requirement of an academic and career plan. This approach would be valuable to the individual student, as well as to the recruiter, academic advisor, and the guidance counselor.

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Incorporating Behavioral Medicine into the Counselor Education Curriculum

Jan Gill-Wigal, Charles Thorne, and Sandra McBee

Mental health professionals are being asked to work in medical settings without adequate training. The inclusion of behavioral medicine in counselor education curricula is proposed.

A new partnership of mental health and medical care has formed in the last decade because of the expanded awareness that elements of psychology are significant with regard to health and illness (Gatchel, Baum, & Krantz, 1989). In fact, psychological therapy has not only gained acceptance in the medical community but is being advocated for the treatment of difficult patients (Blanchard, 1992).

Individuals with psychological problems often turn to their primary care physicians. Although medical training programs have incorporated behavioral medicine into their curricula to address this need (Agras, 1992), it is extremely unrealistic to think or even expect physicians would have time to do necessary counseling. With this in mind, it would follow that those seeking help for psychological problems need to be referred to mental health professionals trained in behavioral medicine. Clinical counselors could find opportunities in the health care arena.

This article is an attempt to define behavioral medicine and to address ways in which counselor education programs can incorporate behavioral medicine courses into existing curricula.

Behavioral Medicine: What is it?

Behavioral medicine is a rapidly evolving specialty that uses behavioral science knowledge and technique to help deal with the prevention, diagnosis, and remediation of physical health problems (Thorne, 1989). The acceptance of the biopsychosocial model in medicine suggests a promising future for this relatively new area. This field takes a holistic view of the client by creating an understanding of the interactions among the physical, emotional, social, and spiritual domains of life (Nicholas, 1988). One cornerstone of behavioral medicine is its reliance on interdisciplinary collaboration (Gatchel et al., 1989), with the integration of methods from medicine/nursing, public health, counseling psychology, and sociology into a unique and vital field (Belar, 1988).

Blanchard (1982) suggested that three events in the 1970s helped to create the field of behavioral medicine as we know it today. In the late 1960s behavior-oriented therapists began to use traditional behavior therapy to treat disorders such as obesity. Biofeedback was developed and utilized to treat psychophysiological disorders. Finally, some infectious diseases were conquered and medicine began to focus on diseases that were to be managed rather than cured.

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Behavioral medicine will continue to develop as varied social changes open the way for increased opportunities to further this field in health care (Nicholas, 1988). Changes in terms of individuals striving to live longer and fuller lives with chronic illnesses have increased the potential for the inclusion of behavioral medicine into traditional medicine. Cost effectiveness is also a significant factor. Other contributing factors include proposed changes in delivery and financing of medical services and the overall shift in society's attitudes toward health and ways to remain healthy (Nicholas, 1988). Finally, related opportunities for behavioral medicine are the contributions to health care research and clinical practice and the facilitation of connections among medical personnel with diverse backgrounds and perspectives (Altman & Green, 1988).

Current Status of Counselor Education

Currently the Council for Accreditation of Counseling and Related Educational Programs ([CACREP], 1988) requires a 72-quarter hour or 48-semester hour master's degree. Students take core courses in human growth and development, social and cultural foundations, life-style and career development, helping relationships, and group process. Students have opportunities to gain knowledge in specialized areas such as alcohol/drug, family, child, and women's issues. No coursework in behavioral medicine is included within the CACREP guidelines.

Suggested Core of Training

Altman and Green (1988) suggested that the core of training in behavioral medicine include four basic areas: basic and applied research, direct service delivery, public policy, and program evaluation.

Basic and applied research, a staple of most graduate programs, is needed in behavioral medicine as with any other professional discipline, to allow students to focus on projects which will allow for advancement in their field.

Direct service delivery is the second element of recommended behavioral medicine curricula. Members of the Society of Behavioral Medicine have shown particular interest in direct health care and health promotion (Altman & Green, 1988). Counselors are taught the importance of personal characteristics in effective delivery systems of front line mental health care. Corey, Corey, and Callanan (1988) suggested that the personal attributes of the counselor are "the single most important determinant of successful therapy" (p. 28). Counselors could be extremely helpful in working with physicians and other health professionals in delivering quality direct service care.

The third suggested component of graduate training in behavioral medicine is public policy training. Public policy training deals with policies that take into account the community and environment (Best & Proctor, 1988). Through this training, experience may be gained to help future counselors educate the public and change public health policy to meet the comprehensive mental health needs of the community as well as the individual.

According to Altman and Green (1988), the final desired component of behavioral medicine curriculum is program evaluation. Program evaluation is particularly important for both quality and future content.

Further Suggestions for Curricula

The behavioral medicine curriculum also needs to focus on the social and psychological bases of health and disease. Students need exposure to the health care

system (Belar, 1988). The opportunity for students to develop communication skills with other medical disciplines is needed with both mentoring and supervision (Belar, 1988) for counselors to have role models and consultants.

Practicum and internship placements for counseling students in behavioral medicine in hospitals or related medical settings could provide counseling students with direct exposure to a knowledge base beyond the discipline of counseling psychology (Altman & Green, 1988).

Many counseling programs could expand the existing studies of legal and ethical issues to include dilemmas unique to medical settings.

The counseling consultation course could offer awareness of the dynamics of consulting with other disciplines. The voluntary, nonhierarchial relationship between two professionals of different occupations involves the structuring of role relationships and providing an atmosphere where the consultee feels accepted and comfortable (Brown, Pryzwansky, & Schulte, 1991). Consultation skills would enable the counselor to help professionals understand the dynamics of human interactions in the medical setting and become aware of the personal conditions that may affect their functioning (Corey et al., 1988).

An additional suggestion would include a multidisciplinary faculty from nursing, public health, and sociology to bring the core courses in behavioral medicine to the students (Altman & Green, 1988).

Summary

Behavioral medicine is a rapidly growing field in medical settings. Physicians are often the first health care professionals that clients seek when dealing with psychological concerns. Although some medical disciplines such as family practice are beginning to address the connection between mental and physical health, psychological service appears inadequate.

Counselor education programs have not yet offered students the opportunity to develop skills necessary to work in medical settings despite the fact that job opportunities are opening in this area.

Within current counseling curricula, there are numerous opportunities to enhance the training of counseling students to work in medical settings. Counseling curricula could be modified to include focusing on the social, psychological, and medical basis of health and disease. These areas can be addressed by modifying the scope of current course offerings and expanding course choices in related disciplines.

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A Comparison of Screening Procedures in CACREP and Non-CACREP Programs

John R. Bradey

A comparison was made between CACREP and non-CACREP counseling programs with regard to screening procedures used after admission and to the adequacy of screening procedures for typical students and students who experience mental health problems. CACREP faculty rated their screening procedures as more adequate overall, and both CACREP and non-CACREP faculty rated their procedures as less effective in screening students with mental health problems.

Research has been conducted on the selection of candidates for counselor education programs (Harvanik & Golsan, 1986; Hosford, Johnson, & Atkinson, 1984; Redfering & Biasco, 1976). Very little research, however, exists on the process of screening students after they have been admitted to counseling programs. An effective screening process for counselors in training is not only needed but also mandated by ethical standards (American Counseling Association [ACA], 1993). Counselor educators should be concerned about the effectiveness of their screening procedures, not only for students with academic problems, but also for students with symptoms or behaviors which could impair counseling effectiveness.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is an accrediting body created by ACA to provide a nationally based standards review process for graduate level preparation in counseling. CACREP was incorporated in 1981, and since that time approximately 195 programs in 72 institutions have received and maintained accreditation.

Researchers have concluded that CACREP-accredited programs are in a more advantageous and competitive position regarding such factors as increased student and faculty pride, university support, faculty involvement, and increased student enrollment (Cecil & Comas, 1986; Cecil et al., 1987; Stickle & Schnacke, 1984; Vacc, 1985). Knowledge, skills, and experience that characterize counseling should be well defined and demonstrated by those who represent accredited programs.

One of the primary functions of ACA is to assist the public and other professionals to understand the role and function of professional counselors. Uniformity in the standards for training counselors would help to enhance the credibility of the profession and increase the probability of graduating competent counselors. Since CACREP accreditation provides the structure needed for the professionalization of counseling, it is likely that counselor training programs will continue to seek CACREP endorsement.

According to CACREP standards (Section V), it is the responsibility of counseling faculty to monitor student progress in the areas of academic performance, professional development, and personal development. Of particular concern to counselor educators should be the careful screening of students who exhibit mental health problems. According to the American Counseling Association *Ethical Standards* (1993), Section H, "Members through continual student evaluation and appraisal must be aware of the personal limitations of the learner that might impede future performance. The instructor must not only assist the learner in securing remedial assistance but also screen from the program those individuals who are unable to provide competent services" (p.7). This has added significance as counselors continue to promote themselves as well-trained competent professionals who serve a vital role in the prevention and treatment of mental health problems.

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Bradey and Post (1991) conducted a national study of the screening procedures used in counselor training programs. They found that most programs have formal, ongoing screening procedures in place, and that the faculty are generally comfortable with and clear on stepwise screening procedures for the "typical" student. They are, however, more unsure about the procedures to follow with the atypical student, such as the student with mental health problems.

Olkin and Gaughen (1991) surveyed 100 graduate level clinical programs to gather information on policies and procedures used in evaluating and dismissing students. Most of the programs surveyed (76%) identified one to three problem students per year. Most students were identified for academic deficits, while others were identified for interpersonal or intrapersonal problems (e.g., substance use, emotional problems, personality disorder). Almost half of the programs did not routinely evaluate intrapersonal functioning. No comparison was made between accredited and non-accredited programs. The authors suggested that screening policies and procedures should be clearly written and made available to all students and that students should be routinely evaluated on both academic and non-academic dimensions.

The purpose of this study was to compare CACREP and non-CACREP counselor training programs with regard to the adequacy of ongoing screening procedures, and in particular the adequacy of screening procedures for students who exhibit mental health problems. Hypotheses were: (a) CACREP program faculty would rate their programs as significantly more adequate in screening students in general than non-CACREP program faculty, and (b) CACREP program faculty would rate their programs as significantly more adequate in screening students with mental health problems than non-CACREP program faculty.

Method

Instruments

A questionnaire, Screening Procedures for Master's Level Counseling Programs, was developed for the purpose of gathering specific information about ongoing screening procedures used in counselor training programs. There were two categories of questions: (a) demographics (e.g., How many students are enrolled in your Master's program? How many faculty members do you have?) and (b) screening procedures (e.g., Do you have ongoing screening of students? Are students aware of screening procedures? How adequate are your screening procedures?). There were three questions that required short written responses. These questions asked for a description of ongoing screening procedures after admission, a description of screening procedures for students who exhibit emotional problems, and a description of how students are made aware of the procedures (e.g., departmental brochures, handbook).

Procedures

A total of 100 master's level counselor education programs were selected to participate in the study. Fifty CACREP-approved programs and 50 non-CACREP-approved programs were randomly selected from over 300 across the United States, using *Counselor Preparation 1990-1992: Programs, Personnel, Trends* (Hollis & Wantz, 1992). The 100 programs represented each of the four geographical regions: Western, Southern, Midwestern, and North Atlantic. The questionnaires, a cover letter, and a self-addressed envelope were mailed to the counseling department heads in spring 1992.

Data Analysis

A chi-square analysis was completed on all categorical items comparing responses from CACREP-accredited and non-CACREP-accredited programs. This was to determine if

there were any significant differences between response patterns. A *t* test for independent samples was completed on selected items to determine if there were significant differences on ratings of the adequacy of programs to screen students who exhibit mental health problems.

Results

Forty-four (44% response rate) of the questionnaires were returned, 23 from CACREP-accredited programs, and 21 from non-CACREP-accredited programs. With comparable response rates for accredited and non-accredited programs, data were considered adequate; however, caution should be used in generalizing beyond the scope of this study because of the limited sample size.

The mean enrollment for all institutions was 12,859, and the mean number of students enrolled in counseling programs was 138. Thirty-three percent of the students in counseling programs were considered full time, while 67 were part time. CACREP programs had more full-time students (45%) than non-CACREP programs (22%).

Respondents were asked if they had ongoing screening procedures for students after admission to the program. Eighty-four percent of the CACREP programs had ongoing screening after admission, and 64% of the non-CACREP programs had ongoing screening after admission.

Respondents were asked to describe the ongoing screening procedures they used. Same or similar responses were combined into categories. Both CACREP and non-CACREP programs had a wide range of ongoing screening methods. Responses ranged from a "formal faculty review of student progress" to "self-screening," as noted in Table 1 and Table 2. The CACREP programs tended to rely most on a regularly scheduled faculty review process, whereas the non-CACREP programs most often relied upon faculty detection of problems and discussion at faculty meetings. Most noticeable was the wide range of procedures used and the lack of continuity across programs.

Table 1
Screening Procedures and the Percentage of Respondents Using Each Procedure in CACREP-Accredited Programs

Screening Procedure	Percent
Regular scheduling of faculty meetings	40
No formal ongoing screening procedures	16
Monitoring grade point average (feedback to students)	16
Informing faculty of problems detected (all instructors)	12
Reporting progress/problems to student's advisor	4
Faculty conferencing at specified intervals	4
Formal interviewing	4
Evaluating progress in techniques class	4
Evaluating at mid-term	4
Signing for advancement to candidacy	4
Offering written or oral exams, or thesis option	4
Advising and ongoing evaluation	4
Requiring full faculty endorsement after nine hours	4
Offering additional supervision	4
Taking examination	4
Evaluating knowledge/skills	4
Currently developing screening procedures	4

$n = 23$

Note. Percentage totals greater than 100 because some programs indicated using more than one procedure.

Table 2
Screening Procedures and the Percentage of Respondents Using Each Procedure in Non-CACREP-Accredited Programs

Screening Procedure	Percent
No formal screening after admission	36
Informing faculty of problems detected (all instructors)	19
Faculty conferencing and reviewing at specified intervals	14
Monitoring grade point average (feedback to students)	14
Reviewing progress informally	10
Requiring specific courses before advancement to candidacy	10
Evaluating student after certain classes completed	5
Requiring thesis	5
Evaluating interpersonal and professional skills	5
Ongoing self-screening and instructor screening	5
Screening by practicum advisors	5
Signing for advancement to candidacy	5
Advising and ongoing evaluating	5
Formal interviewing	5
Requiring comprehensive exam	5
No monitoring after admission	5

$n = 21$
Note. Percentage totals greater than 100 because some programs use more than one method of screening.

Forty percent of the CACREP programs surveyed indicated they had regularly scheduled faculty meetings for the purpose of screening. Another 28% indicated that they had informal faculty meetings to discuss potential problems, and/or monitored grade point averages with feedback to students. Other responses ranged from "formal interviews" to "ongoing advisor evaluation." The most surprising finding was that 16% of the CACREP programs surveyed indicated that they had no formal ongoing screening procedures.

Of the CACREP respondents, 56% indicated that they had special screening procedures for students who exhibit mental health problems (e.g., inappropriate behavior, poor impulse control, emotional reactivity) (see Table 3). Thirty-five percent of the non-CACREP programs had special screening procedures for students with mental health problems (see Table 4). The difference between CACREP and non-CACREP programs on this dimension was significant ($p<.05$).

Respondents were asked how many students had been temporarily and permanently screened out of their programs over the past 5 years. For the CACREP programs the average number temporarily screened out was 2.9 and the average number permanently screened out was 1.7. For non-CACREP programs the numbers were 3.3 and 1.9, respectively. These figures do not include those students who left voluntarily or switched majors.

Respondents were asked to rate the adequacy of their screening procedures for all students and the adequacy of their screening procedures for students exhibiting mental health problems. Seventy-four percent of the CACREP respondents rated their screening procedures as either adequate or very adequate for screening students in general. However, only 52% of the CACREP respondents rated their screening procedures as adequate or very adequate with regard to screening students with mental health problems. The percentages were lower for the non-CACREP programs, 57% and 43% respectively, but were not significantly different. CACREP respondents were significantly less satisfied with the

Table 3

Special Screening Procedures for Students Who Exhibit Mental Health Problems and the Percentage of Respondents Using Each Procedure in CACREP-Accredited Programs

Screening Procedure	Percent
No special screening procedures	44
Faculty conferencing and reviewing at specified intervals	22
Giving student written statement about concerns	8
Referring to university clinic for evaluation	6
Referring to appropriate resource	4
Reviewing all students by committee	4
Bringing concerns to staff meetings	4
Screening at practicum level	4
Evaluating interpersonal skills	4

$n = 23$

Note. Respondents may have selected more than one category.

Table 4

Special Screening Procedures Used for Students Who Exhibit Mental Health Problems and the Percentage of Respondents Using Each Procedure in Non-CACREP-Accredited Programs

Screening Procedure	Percent
No special screening procedures	65
Meeting with advisor to discuss problems/options	10
Reviewing all students by committee	10
Referring to university clinic or outside agency for evaluation	10
Evaluating interpersonal, professional, and work setting skills	5

$n = 21$

Note. Respondents may have selected more than one category.

adequacy of their screening procedures to deal with students exhibiting mental health problems than they were with the adequacy of their screening procedures for students in general.

Conclusions and Implications

The original hypotheses were not confirmed in that there was no significant difference between CACREP and non-CACREP programs with regard to the adequacy of their screening procedures in general and for students with mental health problems. This is a surprising finding, given the standards and thoroughness of the accreditation process.

This study clearly revealed a wide range of procedures currently in use for screening counseling students. Even though ongoing faculty review was used by several CACREP programs, there was a definitive lack of consistency in screening procedures across programs. These findings pose some interesting questions, among them: Is there any real qualitative difference between accredited and non-accredited programs? Even with clear ethical guidelines and explicit accreditation standards, do accredited programs provide rigorous ongoing screening for students? Why do so many accredited and non-accredited program faculty feel that their programs do not adequately screen students, particularly those with mental health problems?

Especially unsettling was the discovery that 16% of the CACREP programs had no formal ongoing screening of students after admission. This would seem to be inconsistent with ACA and CACREP standards. Perhaps some of these programs place considerable emphasis on pre-admission screening and informal procedures for dealing with students who exhibit behaviors which bring into question their competency to practice counseling. However, since so many respondents questioned the adequacy of their programs to screen students effectively, it would seem most logical to have procedures in place which are clearly defined and understood by both faculty and students.

This study revealed that a variety of procedures exist for screening students, and that some apparently work quite well while others remain ineffective and/or inefficient. There is a level of dissatisfaction among many faculty in both CACREP and non-CACREP programs with their ongoing screening procedures that warrants further investigation. What is it specifically about their screening process that they find inadequate? In which ways could the process be improved? Do faculty members take seriously their role as trainers and monitors for the profession? Do CACREP programs really differ that much from non-CACREP programs in terms of screening students and graduating competent counselors?

Perhaps ACA in collaboration with CACREP should develop specific guidelines for screening students that could be adopted by all counselor training programs. This could serve to improve the quality and adequacy of screening procedures, increase faculty confidence in procedures, and continue to afford all counseling students due process.

Counselors should be more recognized as highly skilled professionals with a knowledge base and training that puts them on a par with other professionals. It would not seem unreasonable that the accreditation process could be the catalyst needed to help the profession forge an identity which engenders internal satisfaction and pride, as well as external recognition and acknowledgment.

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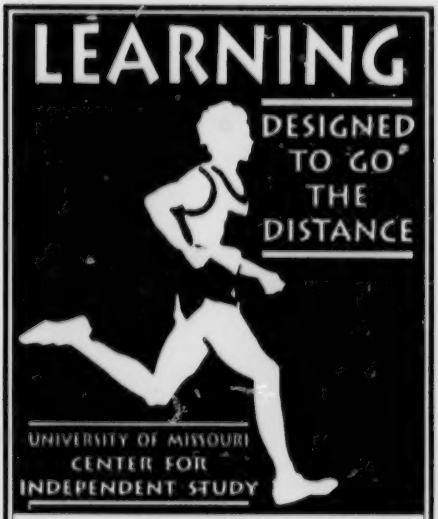

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Theme Feature . . .

Reframing School Guidance and Counseling

C. D. Johnson, Guest Editor

Public school guidance programs across the nation are undergoing changes in the way content is being delivered to learners. In some cases these changes are mandated by local school boards and administrators, while other changes occur because of federal efforts. Many programs have changed because a single professional or a small group of professionals has exerted leadership to bring about the paradigm shift from programs based on providing services to programs based on student results, outcomes, or competencies. All changes appear to be centered on how students are different in the knowledge, attitudes, and skills they have acquired because of the guidance program.

The content of this special journal feature examines changes in state, district, and school. The state of Arizona made the shift from describing counselors' contributions in terms of services provided and roles and functions performed to describing counselors' contributions in terms of what students have learned, the skills they have acquired, and how their attitudes toward school and career planning have improved. The Omaha Public Schools used a different means to make a similar program emphasis shift. Their inclusion of persons that represented all the community organizations affected by the guidance program is exemplary and certainly a model for others to consider in similar efforts. When the shift has occurred from providing a program based on equal opportunities to one based on equity that ensures all students acquire the desired competencies, a reallocation of resources to get the best results occurs. One program at Lincoln High School (Lincoln, Nebraska) reports the effects of such a change motivating counselors to move from individually assigned student case loads to no assigned students, which in turn resulted in moving from being inundated with paper work to managing a centralized effort, and from reacting to students on an as-needed basis to counselors managing their own time and contributions to reach all students.

The change agents had common skills and attitudes, which included the use of systems in thinking and planning, group skills in involving others in TQM (Total Quality Management) methods, and having a personal comfort level for addressing change. All believed that the core of their efforts was the individual student, and that they had to realign current resources in order to provide all students with the necessary knowledge, attitudes, and skills to be contributing citizens. They have shown that individuals and small groups of professionals can cause necessary changes in programs in order to help students and parents.

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The Long Lever: Reframing Guidance in Arizona Schools

Sharon Johnson and Tina Ammon

The guidance programs in Arizona public schools have changed dramatically in the last five years. Arizona change efforts were implemented after considerable research of new models; pilot testing of programs; development of appropriate and relevant materials; a 5-year plan; and the commitment and collaboration of counselors, administrators, state department staff, school board members, legislators, parents, and community members to ensure that all Arizona students graduate from the public school system ready and well-equipped to face the future.

Give me a lever long enough . . .
and single-handed I can move the earth.

Archimedes

Efforts to ensure career guidance for all students in Arizona public schools initiated the reframing of existing programs. The reframing efforts began by defining the gap (needs) between what was currently in place and what was desired. Three major factors provided the stimulus for change:

1. Career education funds in Arizona were eliminated. For many years the vocational education county coordinators assumed responsibility for development of career education activities across the curriculum. However, when funding for career education in Arizona was dropped, no one was specifically trained or available to assume the primary responsibility for career guidance. In some cases teachers retained career education lessons related to their curricula, but the expertise for building an articulated, sequential career development program was lost. No program was offered to assist students to understand the relationship between the career information provided by teachers and their own career development.

2. Counselors were primarily responsive to crises of students, trying to save students in need. Guidance and counseling programs were being offered on the basis of equality, that is, any student could request and receive help. However, none seemed to operate on the basis of equity, which ensures that all students must benefit from the guidance program, including those not actively requesting help or experiencing a crisis. Counselors had an average of 450:1 student-to-counselor ratio, operated from fixed role and function statements, and had no established program to impact all students. In general, guidance had a poor image with the parents, students, administrators, and legislators.

3. Subsequent to the elimination of external funding for career education, a new model, Jobs for Arizona Graduates, a program of job training for at-risk youth through a

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concentrated career guidance curriculum in a classroom setting, was introduced. This model proved ineffective in helping students become more career decided as measured by Osipow's Career Decision Scale (Ammon, 1988). The program results indicated that using a single strategy to produce results with specific students is inadequate. Multiple interventions occurring simultaneously are needed to reach "at-risk" students (Ammon, 1988).

The needs assessment data suggested a direction for change within the existing programs. To identify and measure student progress, change was made from the traditional approach of offering a program of services, processes, and equality to a program of equity that impacts all students, a program founded in competencies, results, or outcomes.

How to Reframe

To start reframing, a systematic change process was initiated, starting with a search of the professional literature and contacting colleagues and professional organizations. The search revealed that the Competency-Based Guidance (CBG) program (Johnson & Johnson, 1983) met the criteria for positive change.

1. The model was developed using a systems approach. "Systems thinking is a conceptual framework, a body of knowledge and tools that has been developed over the past fifty years, to make the full patterns clearer, and to help us see how to change them effectively" (Senge, 1990, p.7). The Johnson model provides for self-renewal as well as self-correction, and is systematic, comprehensive, and developmental (see Figure 1).

2. The model identifies pre-K to Grade 12 student competencies that are developmentally appropriate for all students and are evaluable. A large bank of competencies compiled from a variety of sources allows individual districts to identify the specific competencies most appropriate to their students. For example, a district with a large rural population may use different indicators for specific competencies than a district in an urban setting.

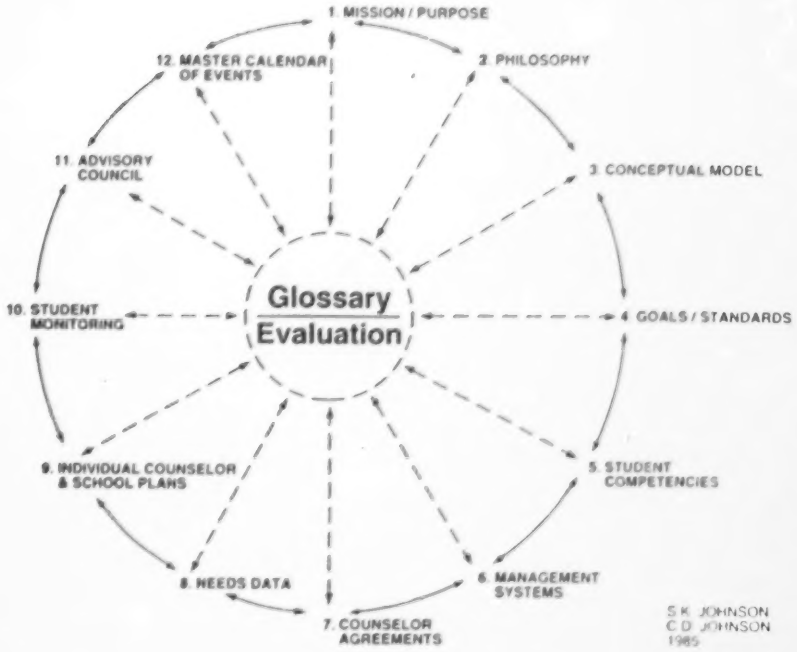
3. The competency-based model provides for full individuality of implementation for school districts, individual schools, individual counselors, and counselor teams, and it promotes creativity in the use of local resources:

- The model allows for differential staffing. Within the model counselors may be assigned to specific areas of expertise such as career development, educational planning, and personal growth; may be assigned to specific populations (by grade level, by first letter of last name); or may have no assigned student caseload (used successfully at Gilbert High School in Arizona, University High School in California, and Lincoln High School and Omaha Public Schools in Nebraska).

- It allows inclusion of competencies from other student-based programs, for example, the National Occupational Information Coordinating Committee (NOICC), the State Occupational Information Coordinating Committee (SOICC), community-based projects for substance abuse prevention, and so forth.

4. A strength of the model for statewide implementation was the inclusion of local community input through advisory councils (Johnson & Johnson, 1972). Parents, community members, school staff, administrators, and students provided input on the specific student competencies, outcomes, and results relevant for their school communities, and recommended priorities in program implementation. This element eliminates the fear of having an inappropriate mandated program that is not tailored to unique community needs and resources.

Figure 1
Competency-Based Guidance Model



5. The model had been developed and used in school districts of different sizes and configurations, and was being successfully implemented with a variety of different populations. Arizona's unique populations demanded use of a model that had proven successful in a variety of settings. The CBG model had been successfully implemented and maintained in districts in 27 states and 9 countries.

6. A 5-year plan for full implementation was suggested, which seemed appropriate in light of the interest in change statewide. It was also important to have a step-by-step, sequential approach to change and 5 years was a reasonable timeline in which to initiate change without losing the initial momentum.

7. The management system includes evaluation of student competencies and program evaluation as an integral part of the program design, thereby allowing counselors, schools, districts and the state to report evaluation data on a regular or as-needed basis. This element was particularly attractive in light of the discontinuance of career education funding statewide. With the potential of reporting progress in terms of student results, legislators could expect to see evidence of the benefits accrued from the funding allocated to guidance.

The Steps to Implementation

The Competency-Based Guidance model was recommended as a framework for guidance for the state of Arizona by Tina Ammon, State Supervisor of Guidance and Counseling, in her capacity as a member of the Arizona Guidance and Counseling Task Force in 1986. The task force recommended piloting the CBG program in 6 school districts using Carl Perkins funds. Each pilot site agreed to produce a videotape and accompanying curriculum module on one of the program elements to be used for counselor training. Within a short time, the pilot sites collected data validating predetermined student results. One site reported that student requests for career plans doubled and resulted in the school board increasing the number of counselors. School board members soon became aware of the program and were able to recognize the benefit to all students.

The Guidance and Counseling Task Force developed and submitted a 5-year plan for statewide implementation. The first step was piloting the program and producing training materials. Second, a steering committee was organized to oversee the development of a state handbook that would meet the needs of all districts choosing to make the paradigm shift from their current guidance program to the competency-based guidance model. Representatives from school districts, the Arizona School Counselors Association, and the Arizona Department of Education worked to ensure that the materials developed were flexible enough to allow individual districts to design their own programs. The resulting framework also provided enough structure to encourage networking among districts, schools, and individual counselors. Adoption of one model facilitated reporting of evaluation data in a standard format that could be used for future funding requests. As a result of the teamwork and planning, committee members developed a thorough understanding and appreciation of the task ahead, that of initiating change statewide based on selling the idea of competency-based guidance to counselors, administrators, school board members and legislators.

The monumental task of introducing change to 232 school districts with 850 counselors was addressed through the creation of the Counselors' Academy, a training program implemented annually using Carl Perkins Funds. The Academy began in the summer of 1990 with counselors being invited to participate in a 1-week residential training program. As a result of the first Academy, 6 school districts adopted the CBG model. The initial response to the Academy was enthusiastic approval. Each year additional districts and counselors have been invited to join previous participants. The following sequence evolved as the program grew and took shape:

- **Year 1 (1990): Introduction to the CBG model.** The agenda included interactive workshops for counselors who were part of the pilot process, and already implementing the program (sometimes colleagues from the same school or district); presentations from professionals from other states sharing ideas, strategies, and tools; extensive networking; program development; and team building. The goal of the program was to encourage development of a plan of action for each school and/or district to begin implementation during the next school year. Administrators were invited to participate on the last day of Academy to review the plans and to gain an understanding of the model.

- **Year 2 (1991): Implementation.** The second-year agenda included time for counselors to reflect on successes and failures of implementation, network with participants from the previous Academy, and share progress to date. Presentations were given by counselors from the initial pilot sites, and outside presenters from other states using similar models were scheduled. Networking time was provided to encourage counselors to meet with colleagues attending for the first time. Other activities focused on skills in team building, development of joint projects, and sharing information about resources. Administrators were invited for

one day to hear presentations, review progress with counselors, ask questions, and share reactions.

- **Year 3 (1992): Evaluation.** Further opportunities for program development were provided with the addition of program evaluation skills, including data collection and reporting. Completion of plans for all program elements was expected for returning participants. New participants developed timelines for complete implementation. Administrators were again invited for one day to meet with counselors, hear about the progress of other programs, and interact with other administrators.

- **Year 4 (1993): Leadership training.** Participants from initial pilot sites and steering committee members presented concepts and ideas on accepting leadership within the school and community. Presentations on personal power, planning skills, staff development, systems, curriculum alignment, and related topics were added to the agenda for returning participants. Participants reported on their evaluation efforts and on the student results.

- **Year 5 (1994): Completion of program development.** Implementation and evaluation cycles have been completed for the first districts to pilot test the program. Participants will represent counselors beginning the program development process, those in some stage of implementation, and those with fully developed, implemented, and evaluated programs. All returning participants will report back, share successes, and plan next steps. The leadership phase will be expanded.

Results

Between 1990 and 1993, over 123 schools and 53 districts participated in the Arizona Counselors' Academy. As a result, 125 schools are currently implementing competency-based guidance programs, impacting 60,500 students. Many schools not represented during the summer Academy training have adopted the CBG program with the assistance of other schools within their districts. Counselors attending the training have gained the confidence to provide inservice and assistance to colleagues at their schools and in other schools within their districts, causing more schools to adopt CBG than have actually received training.

Implementation of the competency-based guidance approach statewide has resulted in counselors and teachers expanding their vision to incorporate other related programs as opportunities to assist in their efforts to reach all students. The NOICC/SOICC guidelines have been easily incorporated into the framework of student competencies. A statewide program has been started that provides 50,000 *American Careers* magazines, one for each ninth grader. South Carolina's Career Development program has been utilized in the Arizona approach to provide an excellent resource to help counselors reach their goals. The "school plan" element of the model has encouraged cooperation between counselors and teachers to ensure that all students attain the identified guidance competencies. In addition, the Arizona State Department Division of Vocational Technological Education has adopted a new model with a career development strand, providing an additional avenue for counselors to team with vocational teachers. Statewide, *To The Future* booklets and the *Counselor's Guide* have been provided to assist each eighth grader in planning a high school course of study. A 1-day statewide "Careerfest" for middle school students provides information and displays on 160 occupations in seven career areas: agriculture, arts, business, math, home economics, marketing, and technology and trades.

Reports from counselors indicate the following results: (a) improved morale and enthusiasm of counselors, (b) closer cooperative relationships with teaching staff, (c) administrators' appreciation of the structure and opportunity for their input into the program, (d) more time for counselors to work with individual students as a result of providing much

more of the program to groups through classroom presentations, (e) counselors' opportunities to work with all students and to know most of the student body, (f) greatly increased counselor contact with parents, and (g) support by school board members for the guidance program. Counselors who were initially resistant have been particularly pleased with the networking opportunities provided through the Academy experience and have been willing to try new strategies used and recommended by their colleagues from other districts and schools. A synergistic effect has occurred as counselors recognize the support they receive from the State Department of Education staff as architects of the statewide efforts, support from their administrators who attend a part of the Academy program, the power of a shared vision of counseling for the State of Arizona, and the opportunity to plan programs in collaboration with other professionals.

Today, counselors, rather than reacting primarily to crises within their schools, utilize a variety of state and local community resources to ensure success for all students. Multiple vehicles and approaches are utilized using competency-based guidance as the framework. The Counselors' Academy summer inservice workshops, Careerfest, resources such as the *Arizona Handbook*, the *To The Future* booklets, *American Careers* magazine, and the South Carolina Career Development program have become part of the guidance effort to reach all students. Most importantly, this change is a solution from within the system, not dependent upon outside funding or experts. It is not a band-aid approach to fix the ills of "at-risk" students but rather an active, comprehensive approach to prepare all students for the future. It answers the new paradigm question "How are students different as a result of the guidance program?" (Johnson & Johnson, 1991, p. 8).

Conclusion

The "lever" can be long as in the case of Arizona's statewide plan for career guidance, or it can be short as in the case of one counselor at one school beginning the process. Arizona's lever is founded on research-based models; pilot testing of programs; development of appropriate and relevant printed and audiovisual materials; a 5-year plan; and commitment by counselors, administrators, parents, and community members. Central to this lever have been the 4 years of the Counselors Academy residential workshops, where professional counselors learn to create and plan their own guidance program. The enthusiasm, motivation, hard work, and astounding outcomes are the result of the collaboration of counselors, state department staff, administrators, parents, school board members, and legislators who are committed to ensure that all Arizona students graduate from the public school system ready and well-equipped to face the future. The counselors of Arizona have established a high standard for guidance programs.

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Developing A District-Wide Outcome-Based Guidance Program

Stan Maliszewski, Ross Pilkington, and Tommie Radd

Omaha Public Schools improved guidance programs by changing the focus from providing services for students and their parents to providing programs that are defined in terms of student outcomes or competencies. This article presents the models that were considered; the options that were selected; and the development plan used for the design, implementation, and evaluation of the Student Outcome-Based Guidance Model.

There is a trend in the United States to improve public school guidance programs by changing their focus from providing services for students and their parents to providing programs that are defined in terms of student outcomes or competencies. The Omaha Public Schools made this shift beginning in 1986 in response to concerns presented by the Superintendent of Schools and Board of Education. Concerns related to the emphasis on counseling referred students that were in crisis with few programs designed to assist all students addressing areas such as the prevention of problems, career planning, studying, test-taking skills, or skills in making choices and handling conflict. Parent and community advisory committees had voiced similar concerns including perceptions that counselors seemed to be doing little for special education students, students in gifted programs, potential dropouts, and students in other at-risk groups.

In response to these concerns, the District Director of Student Personnel Services formed a set of study groups to address what counselors were currently contributing and, based on their findings, to make recommendations for program change. Findings led to the appointment of a District Supervisor of Guidance whose mission was to develop, implement, and evaluate a pre-K-12 outcome-based guidance program. The following is the sequence of events that led to the current program, which has become a model for other districts to follow.

Beginning the Change Process

The Supervisor of Guidance and six counselors formed the Study Committee and met during the summer to review the literature, contact professional organizations, and call professionals who were involved in change. The committee findings highlighted three paradigms that matched local resources and needs for change. One paradigm by Gysbers and Henderson (1988) identified the elements of a program as well as a four-phase process for change: planning, designing, implementing, and evaluating. A similar model for change was that endorsed and used by the Nebraska Department of Education (Lavaty, 1991): planning, revising, implementing, and evaluating. The third paradigm (Johnson & Johnson, 1983, 1991) consisted of two sets of elements: results, and means to achieve the results. This paradigm defines elements in a sequence that provides an avenue for systematic program change. The elements in order are the results (mission, philosophy, and a conceptual model of guidance goals and related competencies) and the means (management system, results agreements, results plans, analysis of needs data, monitoring student progress, forming

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an advisory committee, defining terms, and completing a master calendar). The model that emerged and was eventually used by the Omaha Public Schools incorporated some elements from each source.

The Superintendent of Schools appointed the 70-member Guidance Advisory Committee made up of representatives of students, parents, teachers, building and district level administrators, mental health agency personnel, counselor educators, Adopt-A-School Partners, the Urban League, and the Chicano Awareness Center. This committee had two functions: to audit results and to make recommendations to the Board of Education (Johnson & Johnson, 1972). It soon became the cornerstone of the outcome-based program development effort. The interactions between the Advisory Committee and the Study Committee occurred as follows: the Study Committee presented a program element to the Advisory Committee which then adapted/adopted/changed the element and presented it to the Board of Education for approval.

Actions Leading to K-12 Program Development

To show the sequence of events by the seven-person Study Committee, the following actions are delineated. A workshop was planned and implemented for the Advisory Committee members, counselors, and administrators on the Developmental Competency-Based Guidance Program (Johnson & Johnson, 1983). This was followed by visits of school officials to the Anne Arundel County Schools (Annapolis, Maryland) to observe how the program helped students to do better in school. After the visit, the Study Committee immediately reviewed and revised the district's statements of mission and philosophy and began a glossary of guidance terms. All three elements were subjected to consensus by principals, counselors, and the Advisory Committee using a modified Delphi process.

Using an existing Model of Guidance (Wellman, 1968) which delineated three content domains, the Study Committee next developed a goal for each: academic, career, and personal/social. Student outcomes for each goal were added; then the goals and related outcomes underwent the same consensus Delphi process with counselors, administrators, and the Advisory Committee. The resources consulted for identified student outcomes were Anne Arundel County Schools, Maryland; Ohio Department of Education; Cleveland School District; Florida Department of Education; Oklahoma Department of Education; and St. Joseph School District, Missouri. All outcomes were validated for developmental appropriateness and for content. Next, the Study Committee provided the Advisory Committee with a set of criteria identified as necessary for implementation of the new program. These criteria or conditions for successful district-wide implementation were:

1. The adopted model(s) must have a research base, and the implementation must be supported and encouraged by school and district level administrators.
2. A carefully planned inservice program for all counselors must be encouraged and supported by the Board of Education and administrators.
3. The outcome-based program must allow for one-on-one crisis counseling as well as school and district level financial support for planning and materials. This includes full-time clerical assistance at each school and a reduction in non-guidance assigned tasks and duties for counselors.
4. Each school must have autonomy as to the delivery system of processes to help students achieve predetermined competencies. This includes the building level guidance directors identifying areas of specialization and interests for each counselor.
5. The job descriptions of guidance personnel must be revised to match an outcome-based program, and must be accepted by the Board of Education and upheld by administrators.

6. A public relations effort must accompany program implementation to show the public the changing contributions of counselors.
7. Ethical and legal considerations must be examined in view of utilizing a comprehensive referral process to community agencies.
8. Area counselor education programs must redirect the focus of training from a clinical approach to learning facilitation.
9. Elementary school counselors must be phased in if there is to be a comprehensive preventive guidance program.

Each of the above criteria or preconditions was satisfied through the collaboration of different community organizations, school-related committees, and the Board of Education over a 3-year period. The next step in the process was to create curriculum guides for use by counselors to assist students to acquire the pre-set knowledge, attitudes, and skills.

The writing team identified curriculum outcomes already present in other subject areas that corresponded with the identified, desired guidance program student outcomes in order to avoid duplication of efforts as well as to create teams of teachers and counselors collaborating on student-based results. This was followed by developing curriculum guides in the three areas of learning, career planning and preparation, and personal-social relationships. Each student outcome had three suggested activities with evaluation criteria and strategies. Counselors were instructed that these were guides only, and that they could use them or develop their own strategies. The purpose was to ensure the students had acquired the desired competencies.

A special document committee was assigned to develop a structure for individual counselor professional development plans. The approved document included professional assessment with recorded training needs related to their area of specialization and responsibility. The actual training or in-service opportunities were provided by district resources. The personal development plan was followed by the creation and acceptance of the *Guide for the Appraisal of Counselors*.

The guide included a results agreement, results plans, and progress reports for each counselor (Johnson & Johnson, 1983). Since the agreements and plans vary from year to year as well as from school to school, there is no standard role and function. Each counselor or counselor team may have different roles each year, but reach the same outcome using different strategies. The means will necessarily vary; therefore, there are different functions. Because each school counseling team is unique, with some counselors having an assigned case load of students, some having an assigned specific domain of results, or some having no assignment, there are varying roles within each school as well as in the district. Instead, counselors are valued and assessed on their contributions to the education of students, that is, how students are different because of the guidance program. These contributions are acknowledged in the annual review through the following categories delineated in the guide:

1. Planning, organizing, and implementing the guidance program.
2. Providing appropriate services to staff, parents, and community.
3. Using applicable guidance and counseling techniques.
4. Performing in a professional manner.
5. Demonstrating appropriate personal qualities.

The guide provided the stimulus for counselors to develop and implement the Student Information and Self-Assessment Folder for each student in grades 7-12. The purpose of the folder is to provide a means to monitor each student's progress in developing a post-high school educational and career plan. The information recorded in the folder includes a record of competencies demonstrated, self-assessment, standardized test results, work history, and

other information that might be relevant in preparing a resume and a college or employment application. The folder belongs to the student and is taken when the student is ready for graduation or checks out of a school.

The final element of the program to be developed was the process of evaluation, that is, how successful the counselors were in delivering the student outcomes they had planned (Johnson & Whitfield, 1991). A data flow system was designed to include the collecting and reporting of formative data for use in program improvement. Data were collected and summarized by the counselor and then reported to the principal. The principal reviewed and validated the results. School composite results were forwarded to the Supervisor of Guidance, who prepared a report for the Superintendent. After approval the report was shared with the Advisory Committee and then with the Board of Education. Yet to be added are the summative or "impact" data (Johnson & Whitfield, 1991).

Summary

There are several important steps to developing a guidance program that will result in support for additional resources. First and most important is the decision to make the paradigm shift from guidance processes or services to a student outcome- or competency-based program. The second is to use a systems approach (Senge, 1990) in completing a plan that allows for maximum input from the appropriate persons in the school community. The third key is to allow enough time to complete all tasks thoroughly at the highest level of quality. Most school districts allow three to five years. Finally, it is important to remember that guidance is not a program that stands alone; it is one element or part of the school's efforts to help all students become successful by acquiring the competencies required to be productive citizens.

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Who Is Your Counselor? Does It Really Matter?

Mary Beth Lehmanowsky

When the counselors of Lincoln High School changed the guidance program from providing services to students, parents, and staff to ensuring that all students acquire specific competencies, major changes in the use of current personnel and resources resulted. The counselors moved from assuming that each counselor had to know and do everything for individually assigned students to differential staffing and from "doing" tasks to managing processes and resources as needed to complete specific tasks.

". . . to systematically provide Guidance and Counseling services to all students which facilitate growth and development toward their full potential" (Lincoln High School, 1993). So reads the mission statement of the Lincoln High School Counseling Center. In 1985 the mission statement of the Lincoln High School counselors was not articulated–but in fact was to deliver guidance and counseling services to students who were alphabetically assigned.

The services delivered were determined by individual counselors and students who received the services. Those students most frequently served were often academic stars or students who were in trouble with someone. Even though the percentage of the student body that was seen was small (except for registration), the scope of services expected was large –parent to the unparented, financial aid and college planning expert, drug and alcohol abuse interventionist, violence mediator, pregnancy counselor, and family therapist–to name a few.

Each counselor was expected to perform all services for students who were assigned–and expected to do each task equally well. In 1985 the role of the counselor at Lincoln High School was inexplainable, demanding, unrealistic, vague, and unfocused. Counselors' skills, interests, and talents were not considered when tasks were assigned, nor were students' wants and needs considered. The counseling program was whatever the counselors delivered either by choice, administrative edict, or reactions to teachers, parents, administrators, and students who were alphabetically assigned.

The Lincoln High School guidance program is different now; there is an articulated program. The program is student- outcome focused, and the outcomes are based on needs that have been identified by students, parents, and teachers. Systems are in place to assure that all students benefit from the guidance program. Much of the counselors' time is spent in classroom settings delivering guidance curriculum and in small group work. Students are not assigned to a counselor, but are free to see any or all of the 10 counselors. The counseling staff works as a team, with each counselor bringing to the team expertise in specific areas; they work with all students in need of their help. Differentiation also allows counselors to work in areas of interest and encourages their development of proficiency and skill in those domains.

The counselors at Lincoln High School changed the guidance and counseling program. The restructuring was not forced or initiated by the administration at the building level

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or district level, but by counselors themselves. The counselors considered the following issues when thinking about restructuring the program:

1. Relationships cannot be assigned alphabetically.
2. Counselors don't own students or their problems.
3. Schools are built for instruction–not therapy.
4. Counselors have different interests, talents, and skills.
5. Guidance and counseling should be for all students, not just those with problems.
6. If counselors want to reach students, they should go where students are–classrooms, playgrounds, lunch areas.
7. Counselors should spend as much time in preventive activities as in reactive activities.
8. Counselors should define the counseling program.
9. Guidance-counseling is an instructional program, not an assortment of services.
10. Students with problems are the responsibility of the entire school staff, not just counselors.
11. Students, teachers, administrators, and parents need to know what counselors contribute; counseling needs to be demystified.
12. All students deserve the best possible help they can get on specific issues and needs.
13. Counselors need to know and be able to explain how students are different as a result of their efforts.

The decision to change is never easy and is always personal. Change makes misfits of us all–veteran counselors become "new" counselors when programs are centered around student outcomes and there are no longer "my students." The counselors at Lincoln High School have worked diligently for the last six years to improve and create the guidance and counseling program. Managing the change process and restructuring the operational system required thorough planning, cooperation, teamwork, devotion, and hard work. Counselors had to agree on philosophy, student outcome statements, and daily operational procedures. The following is a description of the process that was followed by the counseling staff as it began to transform the guidance and counseling program at Lincoln High School from a traditional therapeutic model to an outcome-based program for all students.

The Planning Process

In 1984 Lincoln Public School counselors were given the opportunity to attend two in-service workshops on the topic of outcome-based guidance programs. Gysbers and Moore (1981) and Johnson and Johnson (1983) emphasized the need for guidance and counseling programs to be student competency- or outcome-based. Following the workshops, in weekly counseling meetings, the Lincoln High School counselors discussed ways to improve the counseling program. The emphasis of a program change would be to serve all students rather than just those who sought out the counselors (Myrick, 1987). To serve all students the counselors had to de-emphasize individual counseling, be more proactive in their approach, focus on specific guidance outcomes, and utilize the classroom as often as possible in an effort to reach the most students.

Various activities and teaching units addressing specific student outcomes were discussed. Each counselor had high interest and expertise in categorical guidance areas. The counseling staff considered ways to use their individual talents, skills, and abilities in the guidance program. It was agreed that differentiation of responsibilities and duties was the most efficient and productive approach. For record-keeping purposes the administration wanted students to be assigned to counselors, but on a day-to-day basis counselors were

diligent in the practice of getting students to the counselor most knowledgeable in the area of expressed need. However, after the first year students were no longer assigned to a counselor for any reason. It wasn't necessary.

As the year progressed, counselors noted real advantages for the students and for themselves. Students were getting help from counselors who had the most knowledge in specific areas. They were making contacts with several counselors and in doing so were learning that help was available from more than one source. Most importantly, the students were forming relationships with counselors based on preference and need rather than on assignment. Students did not have to wait to see "their counselors" because a counselor was always available. As the school year came to a close, counselors requested funding from the school district for a summer workshop to evaluate what had happened in the previous year and to make plans for the coming year.

In the first summer workshop, the counseling staff discussed the merits of a counseling center approach rather than the traditional approach where students are assigned to one all-purpose counselor. After considerable discussion among counselors and administrators the decision was made to take the plunge and move to a system of having no students assigned to a specific counselor (multicounselorism!).

The next move was to list all the guidance functions and responsibilities currently being performed by the counseling team. Individual counselors claimed specific areas of responsibility and made a commitment to oversee the delivery of results in those areas. No counselor was assigned tasks not desired nor was there concern about who would work the hardest, or who had the most important job. This formalized the process that had been followed the previous year and also specified areas of accountability for each counselor. In addition to the responsibilities in specialized areas, counselors were responsible for individualized counseling and the performance of general duties assigned to all school staff members. They were involved with the registration process, writing letters of recommendation, educational planning, and other activities traditionally performed by counselors.

The counseling staff next agreed on student competencies they felt to be important for all students. At first, counselors chose outcomes for students using experience and knowledge–now Lincoln High School counselors pay close attention to the needs assessment survey results given to students, parents, and teachers. For each student competency identified, the counseling staff has a plan assessing all the students in the school and identifying processes or methods of instruction. An example of a student competency statement is: "I can identify resources to use for academic, personal, social, family, and health concerns." The plan to address this outcome was fairly simple in terms of process, but not so simple to deliver to 2,200 students. A colorful, easy-to-read brochure was designed by counselors listing all the resources available at school. A lesson plan was written to teach the importance of knowing when and where to get help. Each counselor went into a different classroom one period a day for 16 days to give students a copy of the brochure and teach the lesson on resources available to youth.

Focusing on student outcomes, non-assignment of students to a counselor, and staff differentiation, the counselors worked out changes in the daily operational procedures that would be necessary to assure accountability.

Daily Procedures

Now at Lincoln High School each student, in effect, virtually has 10 counselors. Students are not assigned to a counselor, but are free to see whomever they choose. Each counselor has specific areas of expertise and responsibility, so generally students see a particular

counselor based on the nature of the service or help they are requesting. For routine questions or scheduling issues, students see the response counselor, who is also available for walk-in students and crisis intervention. One day a week each counselor works as the response counselor, who schedules no classroom or group work, no meetings, and no appointments or activities outside of the office. With this procedure, the counseling center is always staffed. If a student wants to see a specific counselor who is not available at the moment, the student signs an appointment calendar on the counselor's door, and is called to the office when the counselor is available. Counselors not "on call" that day have the opportunity to do group work, classroom presentations and teaching units, student counseling, parent conferences, teacher consultations, and guidance planning without interruption.

An accounting system for documenting student contacts was developed for teachers, administrators, parents, and other counselors. Each counselor records student contacts using a daily sheet to list the student's name and describe the nature of the contact in a word or two. At the end of each day, each counselor submits a log sheet to the counseling center secretary, who records the information on individual student cards. The cards are filed alphabetically in a central location which enables school staff to review a student's card and see which counselor has worked with that student and for what reason. Since confidentiality is important, information on the card regarding the student contact is very general.

All student records were moved to a central location so each counselor has easy access to student files and student educational plans. A counseling technician keeps all files and records current and routes pertinent student information to counselors on a daily basis.

Delivery of Results

As mentioned before, counselors work in specialized areas and are responsible for the delivery of guidance and counseling activities and results in those areas. With student outcomes in mind, the counselors design programs or activities in their area of specialization to meet student needs. Under the two general categories of educational and career development, and personal and social development, five specific categories help define the contributions and required professional competencies of the counselors (see Table 1).

Counselors working in the continuing education area assist students interested in continuing their formal education after they graduate from high school. Post-high school planning is a concern for all students. Four counselors work extensively in this area, using classrooms for primary access to students. Students wishing to attend a 4-year college are given assistance in all stages of the process, ranging from selecting a college to obtaining financial aid. Counselors schedule college representatives' visitations, meet with small groups of students for college entrance test preparation and interpretation, assist in computer-guided college searches, disseminate information about scholarships, and help students apply for scholarships. Students wishing to attend a 2-year college or technical school receive the same assistance. The goal is to help students be as well prepared as possible for post-high school opportunities. Each student has a plan that reflects post-high school plans, academic ability and talent, and graduation requirements. The plan is made with counselor assistance in a career and educational planning class that is a requirement for all students at Lincoln High School.

In the area of programs for affective education counselors focus on peer resource programs and affective education classroom presentations or lessons. Topics such as depression, stress, divorce, grief, and teen suicide are examples of the issues addressed in small groups, classroom presentations, panel discussions, and youth seminars.

Table 1
Lincoln High School Guidance & Counseling

Educational and Career Development

Continuing Education

- Coordinate and manage college selection and application process
- Coordinate and manage community/technical college selection and application process
- Coordinate and manage scholarship information and application process
- Coordinate information about military opportunities
- Coordinate and schedule visits of military representatives
- Direct ACT/SAT preparation and interpretation
- Coordinate administration of PSAT
- Arrange out-of-school learning opportunities
- Conduct liaison with job training programs
- Consult and coordinate with career and education planning classes
- Coordinate preparation of letters of recommendation
- Provide NCIS services
- Consult and coordinate with vocational educational departments
- Coordinate with gifted programs

Educational Progress Management

- Coordinate educational planning session to develop 4-year plans
- Coordinate monitoring of students' 4-year plans
- Coordinate revision of 4-year plans as needed
- Coordinate monitoring of student academic progress
- Coordinate review of student schedules for requirements
- Coordinate progress checks and status report letters to students and parents
- Monitor progress reports/grade reports and coordinate academic support and response
- Register new students

Team Leadership

- Coordinate registration for classes
- Coordinate management of late graduation contacts and summer school registration
- Plan public relations for department
- Facilitate guidance information to staff
- Serve as department spokesperson/liaison with staff
- Coordinate support delivery for new staff
- Monitor and support delivery of guidance and counseling program and services
- Chair guidance advisory committee
- Attend department chairperson meetings
- Develop guidance and counseling program plan

Personal and Social Development

Programs for Affective Education

- Coordinate peer helping program selection, training, and outreach programs
- Coordinate student mediation program selection, training, and mediation process
- Plan and deliver program for helping resources education
- Coordinate and teach helping skills for teachers and conflict mediation skills for staff workshops
- Plan and deliver crisis education/response management
- Develop and coordinate delivery of selected guidance curriculum in classrooms

- Teach steps of success classes for sophomores
- Coordinate follow-up program for steps of success students
- Arrange and conduct counseling groups
- Provide individual counseling and crisis intervention
- Make referrals to alternative educational programs
- Coordinate with teen pregnancy program
- Participate in intervention core team and support groups
- Serve on drug prevention team

Development and management of the Peer Helping program is a responsibility of the counselors in this area. Students are trained in a semester course in communication skills, helping skills, and responsibilities and ethics of helping. Once trained, students help their peers by reaching out to those students who are lonely, socially isolated, or who are having personal problems (Varenhorst, 1983). The Student Mediation program in which students are selected and trained to mediate non-physical disputes among other students is also managed by counselors in this field. The establishment of a peer network using students as resources to each other in a variety of formats is a strong priority for counselors working in this domain.

One counselor is responsible for monitoring all student records. This counselor is not responsible for all student records but does make sure that each student has a viable 4-year plan, registers all new students who enter school during the year, drafts letters to parents of students who will not graduate with their class, and organizes work lists for the counseling staff when tasks are so large they require the work of several counselors.

Counselors who work with students-at-risk teach a semester class in which school survival skills are emphasized. Students in the class are sophomores who have been identified in junior high by district criteria as potential drop-outs. Programs are also provided to those students who develop problems of nonattendance and who are experiencing personal problems that make staying in school difficult. Early intervention is critical when dealing with students-at-risk and for this reason counselors in this area spend most of their time teaching classes, facilitating groups, and providing individual and crisis counseling for those students who have a difficult time staying in school.

The team leader or department chair for the counseling center is responsible for coordinating and monitoring the contributions of the counseling staff. The team leader works with the educational progress management counselor to plan and schedule all duties having to do with monitoring students' academic progress towards graduation. Registration, academic planning sessions, and senior progress checks and notification are examples of responsibilities assumed by the entire staff but which are delegated by the team leader. The team leader is also responsible for chairing weekly counseling team meetings, serving as spokesperson for the department, educating and informing staff and parents about the counseling program, and developing and evaluating the program.

Evaluation of Results

In 1986 at the end of the school year (the first year of non-assignment) a random sample of 33% of the students at Lincoln High School responded to a survey about the counseling center. Ninety percent of the respondents reported they liked having the option of working

with the counselor or counselors of their choice. Eighty-two percent of the students indicated they had received help from a counselor during the year. Now, six years later, data confirm that students are comfortable with non-assignment. Counselors see most students in classroom settings. "Who is your counselor?" is a question not asked at Lincoln High School. Students like to work with counselors of their choosing and do not feel a need to be assigned to a specific counselor.

Conclusion

Making changes in counseling program is indeed like living in a house that is being remodeled (Hargens & Gysbers, 1984). Remodeling jobs usually occur because something is outdated or is no longer meeting the need for which it was once intended. This was certainly the case in the counseling department. Counselors were doing a good job of what they were doing, but what they were doing was inadequate in terms of meeting the needs of the majority of students in the school. The model described in this article benefits students, their parents, and their counselors. Students are served by a variety of counselors who use their unique skills and talents to aid a large number of students. Schools are built for instruction, not counseling (Gysbers & Moore, 1981). Counseling programs that parallel instructional programs are more effective in schools than are those programs existing in isolation from the total school program.

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"Counseling is about working with people."

– Benjamin Reddish, Jr.

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Feature . . .
The Personal Side of Counseling . . .

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The Helping Person's Credo

by Henry L. Levy

I want an atmosphere
In which we are together comfortably
free of distraction, without interruptions,
quiet, private, confidential.

I want us to be free to express ourselves,
to be without fear
of criticism, judgment, contempt, rejection.
I want us to be together as equals
with no condescension, coercion, retaliation.

I want to open myself, to receive
you with no preconditions, claims, or stipulations
that may limit your self-searching and self-expression.
I want us to be authentically ourselves.

I want you to be able to face your weaknesses, defects, limitations,
and the rejected parts of yourself without fear,
shame, guilt, self-condemnation.

I want you to be able to come out
of hiding, denying, protecting, disguising yourself.
I want you to have the courage to confide
in me, trust me.

If you rebuff me, challenge me, try to provoke me, test me,
to confirm my trust and caring, I will understand.

Henry L. Levy is Psychologist in Private Practice in Hermosa Beach, California.

I want you to reown and reclaim
the disowned parts of yourself, to know your essence, your worthiness,
to accept yourself, to love yourself, and nurture this love.

I want you to understand that our relationship is beyond theories, methods, and techniques. These are secondary to our relationship.
I want no rigid recipes, no tricks for manipulating,
conditioning, dehumanizing, or making an object of you.
Whatever I do will be open, disclosed, explained, and used only
with your acceptance.

I believe in you, in your intrinsic worth.
I am interested in everything that has happened and is happening to you.
There is nothing sinful, shameful, nor despicable in you. I am open to you unconditionally. I respect you, value, care for you. I welcome you as you are.
I do not expect your dependency, gratitude, admiration, nor love.

I want you to discover yourself
and arrive at being who you are.

I want us to have the mental and emotional maturity,
the patience, the understanding, and wisdom
to illuminate the dark, shadowy path
upon which we travel.

I want to rejoice with you triumphantly
in the light, the clarity, the truth, the harmony,
and the beauty of your discoveries.

I want a mutual creativeness, a common transcending communication,
ending with your renewed re-entry into the exciting current of life,
with continuing movement of self-realization,
and growth.

• • • •

Binding Pact

by Sharon Rizk

Fine.
Then I shall call you common.
Compliance under protest
Because I am not wholly ready.

But in some dark and hidden place,
Where even I may know me not,
I will fiercely grasp transgressive faith
and hold aberrant communion,
However brief and bittersweet.

For the alternative, however full,
At least for now, still leaves me
Baring less and wanting more.

Sharon Rizk is Marriage, Family, and Child Counselor Trainee, Pasadena Mental Health Center, Pasadena, California.

"As counselors, we are supposed to be change agents. We are, however, sometimes the most resistant to change. We need to reach out to the customer–the client, make conscious choices, and work toward positive, focused change."

– Benjamin Reddish, Jr.

• • •

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A Proposed Category for the Diagnostic and Statistical Manual of Mental Disorders (DSM): Pervasive Labeling Disorder

David A. Levy

The purpose of this article is to propose a new diagnostic category for inclusion in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, better known as the *DSM*. As noted in its third edition (American Psychiatric Association, 1987), the *DSM* should be viewed as "only one still frame in the ongoing process of attempting to better understand mental disorders" (p. xviii). The category proposed here represents a significant contribution to the composition of the next still frame by focusing on one of the most ubiquitous, yet least recognized, of all mental disorders.

409.00 Pervasive Labeling Disorder

Essential Features

The essential features of this mental disorder are: (a) an uncontrollable impulse, drive, or temptation to invent labels and apply them to other people; (b) a repetitive pattern of trying to fit people into preconceived categories; (c) an increasing sense of fear or inadequacy before committing the act; (d) an experience of overwhelming triumph or relief at the time of committing the act.

Manifestations of the disorder appear in many situations but are especially likely to occur when the person with Pervasive Labeling Disorder (PLD) feels uncomfortable around other people. The person then spontaneously assigns a label to others, thus viewing them as "types" rather than as human beings. Because the disorder serves to control other people and to keep them at a distance, it provides the person with the temporary illusion of both superiority and safety.

Associated Features

People with PLD frequently display marked signs of arrogance, smugness, grandiosity, and a sense of personal entitlement. They exhibit an especially condescending attitude toward others who do not share this mental disorder.

These persons derive immense pride from inventing seemingly incisive and articulate (yet ambiguous and indecipherable) pseudoscientific neologisms. When called upon to explain the precise meaning of these newly created labels, however, they typically display peculiar speech characteristics and inappropriate communication patterns, including catatonic silence; stammering and cluttering; verbal perseveration on the label, coupled with poverty of content of speech; and psychomotor agitation, such as engaging in beard-stroking, head-shaking, or eye-rolling behaviors.

Persons with PLD operate under the delusional belief that, by having named something, they have therefore explained it (i.e., Delusional Disorder, Nominal Type). Research indi-

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cates that many persons with PLD are exceptionally adept at seeing in other people the flaws they cannot see in themselves.

Prevalence

PLD is widespread throughout all sectors of society, but many persons have found a means to obtain reinforcement for this disorder in socially acceptable ways by becoming psychiatrists, psychoanalysts, psychologists, astrologists, scientologists, evangelists, cult leaders, authors of self-help books, politicians, and interview guests on radio and television shows.

Age at Onset

Despite its prevalence, the disorder is typically not recognized until the person has attained a position of social power.

Course

Recovery from PLD rarely occurs once the person's annual income exceeds six figures.

Complications

Because persons with chronic and severe cases of PLD are incapable of achieving and maintaining any type of human bonding, they rarely have any real friends.

Predisposing Factors

Vulnerability to this disorder is directly correlated with the extent to which one has a fear of one's own feelings. When PLD is found in psychotherapists, it typically serves to mask their deeply hidden and nagging fears that they haven't the faintest idea how to help their patients.

Differential Diagnosis

Obsessive Compulsive Personality Disorder, Social Phobia, and Delusional Disorder (Grandiose Type) are related to, and therefore sometimes difficult to distinguish from, Pervasive Labeling Disorder. To ensure diagnostic validity, flipping a coin, tossing the *I Ching*, or utilizing the eenie-meenie-meinie-moe method is recommended.

Types of Pervasive Labeling Disorder

409.01 Pervasive Labeling Disorder with Narcissistic Personality Features

This category should be used for the person with PLD who you think has too much self-esteem.

409.02 Pervasive Labeling Disorder with Co-Dependency Personality Features

This category should be used for the person with PLD who you think has too much empathy.

409.03 Pervasive Labeling Disorder with Histrionic Personality Features

This category should be used for the person with PLD who you think is too emotional.

409.04 Pervasive Labeling Disorder with Schizoid Personality Features

This category should be used for the person with PLD who you think is not emotional enough.

409.05 Pervasive Labeling Disorder with Neurotic Personality Features

This category should be used for the person with PLD who you think feels too much guilt.

409.06 Pervasive Labeling Disorder with Antisocial Personality Features

This category should be used for the person with PLD who you think doesn't feel enough guilt.

409.07 Pervasive Labeling Disorder with Borderline Personality Features

This category should be used when the person with PLD is disliked intensely by others, especially unsuccessful psychotherapists.

409.08 Pervasive Labeling Disorder with Adult-Child-of-Alcoholic Personality Features

This category should be used when the person with PLD came from parents who, in any way whatsoever, did not satisfy each and every one of his or her needs as a child.

409.09 Pervasive Labeling Disorder with Resistant Personality Features

This category should be used when the person with PLD doesn't do what you want him or her to do.

409.10 Pervasive Labeling Disorder with Cognitive Slippage Features

This category should be used for the person with PLD whom you can't understand, but don't want to admit it.

409.11 Pervasive Labeling Disorder with Transference Features

This category should be used for psychotherapy patients with PLD who have any feelings whatsoever about their therapist.

409.12 Pervasive Labeling Disorder with Countertransference Features

This category should be used for psychotherapists with PLD who have any feelings whatsoever about their patients.

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"In my conversations with colleagues, I am constantly impressed by the professional insights expressed. And I think, and often say, you should put those ideas in a manuscript for us to publish."

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